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Alzheimer's Society United Against Dementia

Optimising nursing care of people living with dementia who transfer between hospitals and nursing homes

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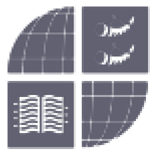

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Supervisory Team

Principal Supervisor: Professor Murna Downs

Co-Supervisor Professor Gail Mountain

Co-supervisor Kathryn Lord

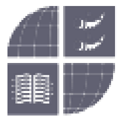
Previous co-supervisor: Professor Alison Blenkinsopp

What is transitional care?

This study is focused on transitional care for people living with dementia when they move between hospital and nursing home.

"a set of actions designed to ensure the coordination and continuity of healthcare as patients transfer between different locations or different levels of care within the same location"

(Coleman et al. 2003:556)



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Session outline

Background

What we know and don't know

Study aims, methods and findings

Discussion and conclusion

What we know: Hospital to care facility transitions

Resident and family outcomes

- Lack of follow up tests and medicines review (*Caruso, et al 2014*)
- Delays in fundamental care
- Risk of falls
- High levels of resident distress
- Re-hospitalisation
- Individual and family dissatisfaction (*King et al 2013; Gilmore-Bykovskyi et al 2017*)
- People living with dementia feeling unsettled and powerless (*Digby et al 2011*)

Health care professionals perspectives

- Insufficient information regarding behavioural symptoms
- Lack of preparation time for preparing transitions, both the person and environment
- Communication between settings requires improvement

(*Gilmore-Bykovskyi et al 2017, Kable et al 2017)*

Richardson A, Downs M, Blenkinsopp A, Lord K. (2019) Stakeholder perspectives of care for people living with dementia moving from hospital to care facilities in the community: a systematic review (*BMC Geriatrics* 19,202)

What we know: Nurses' role in transitional care

- Nurses have central roles within the discharge process (Nosbusch et al. 2011)
- Many NHS hospitals have nurse-facilitated processes (Lees 2012)
- Evidence has demonstrated that nurse-led interventions can improve discharge experience and reduce readmissions (in the home setting) (Naylor et al 2004, 2014)
- Timing of transitions can impact on the nurses' role in care homes or care facilities due to workforce capacity issues *(Gilmore-Bykovskyi et al 2017, Kable et al 2017)*
- Shift patterns and reliance on agency staff can be a barrier for getting to know patients affecting care continuity (Nosbusch et al. 2011)

What we know might help: NICE guidance

Recommends

- Information is shared
- Comprehensive Geriatric Assessment on admission
- Maintain momentum of treatment and discharge planning
- Have a named discharge coordinator
- Family involvement

But

- Systems have made little progress in its adoption
- Specific interventions are not clearly articulated in relation to comprehensive assessment and aspects of care. (National Audit office 2016)

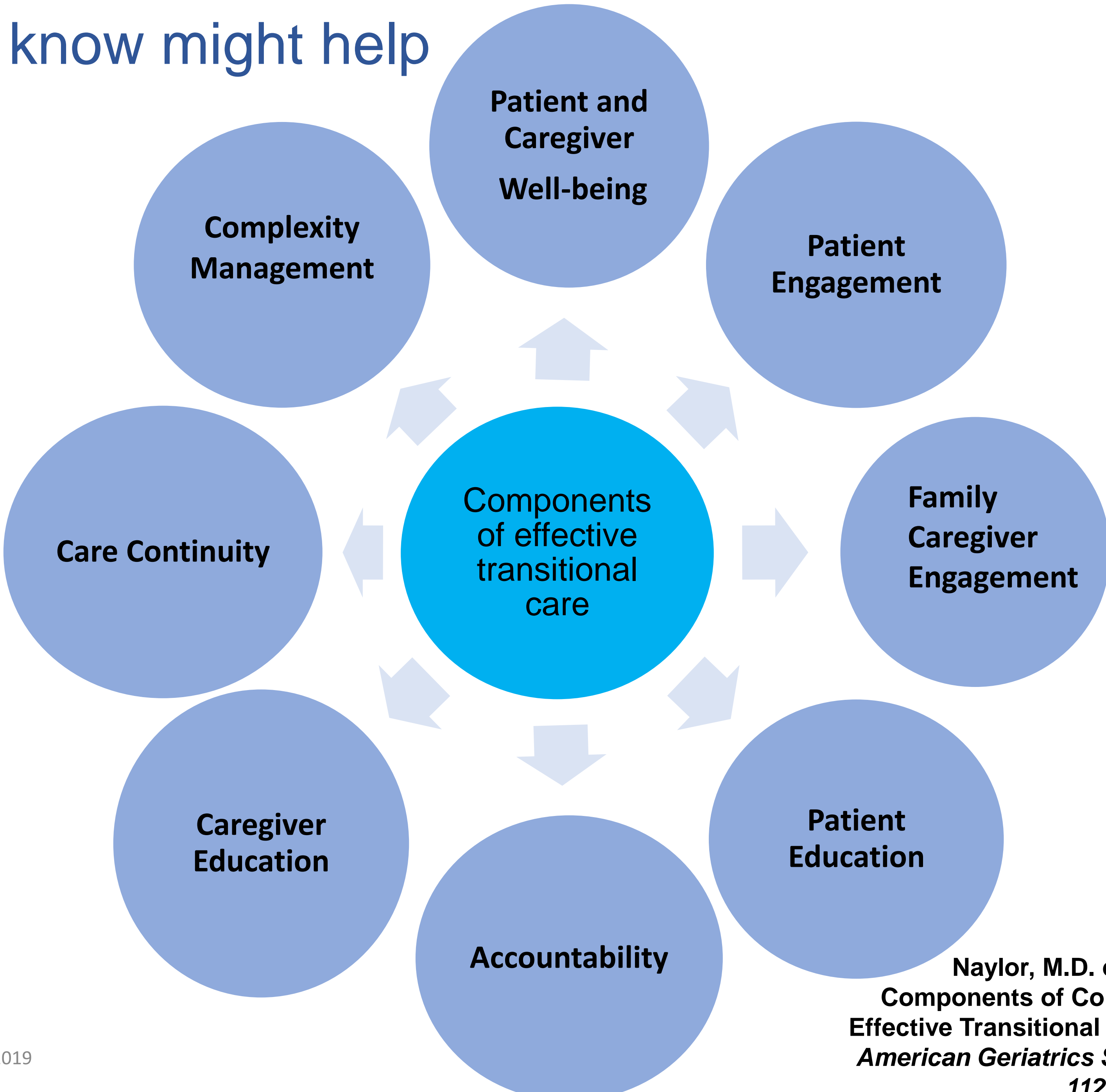
NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Transition between inpatient hospital settings and community or care home settings for adults with social care needs

NICE guideline: full version, November 2015

Transition between inpatient hospital settings and community or care home settings for adults with social care needs: final version (November 2015) 1 of 347

What we know might help



Naylor, M.D. et al. (2017) Components of Comprehensive and Effective Transitional Care. *Journal of the American Geriatrics Society 65 (6), 1119-1125.*

What we don't know….

- Experience for people living with dementia transferring back to care homes
- Nurse perspectives about best practice of this transition in the UK
- Nurses working in the 2 settings – care homes and hospitals

Aim of research

To explore nurse perspectives on the roles they need to perform to ensure quality transitional care for people living with dementia who return to their nursing home from hospital; and the extent to which Naylor’s components of effective transitional care are applicable to this transition

Research questions

1. How do hospital and care home nurses describe their role?

2. To what extent do their perceived roles address Naylor's components of transitional care?

SAMPLE AND SETTINGS

	Hospitals n-=16	Nursing Homes n=17	Total n=33
Settings	2	4	6
Female	15	12	27
Years of experience			
< 5 years	0	1	1
5-10 years	4	7	11
11-20 years	8	3	11
21-30 years	2	3	5
31-40 years	2	3	5

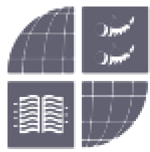
METHODS: Descriptive qualitative study

Advisory group

Semi-structured interviews

Focus groups

Inductive and Deductive Analysis



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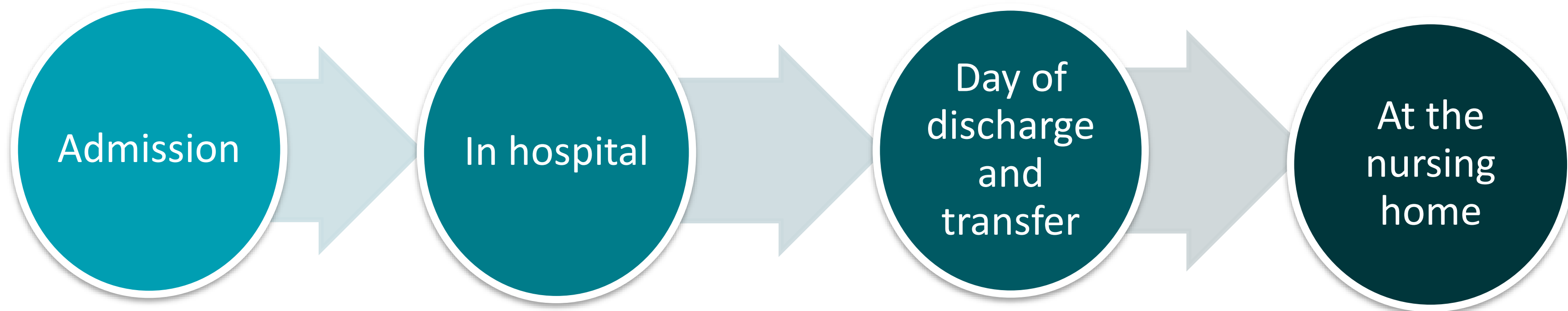
Finding: Nurses' roles in transitional care

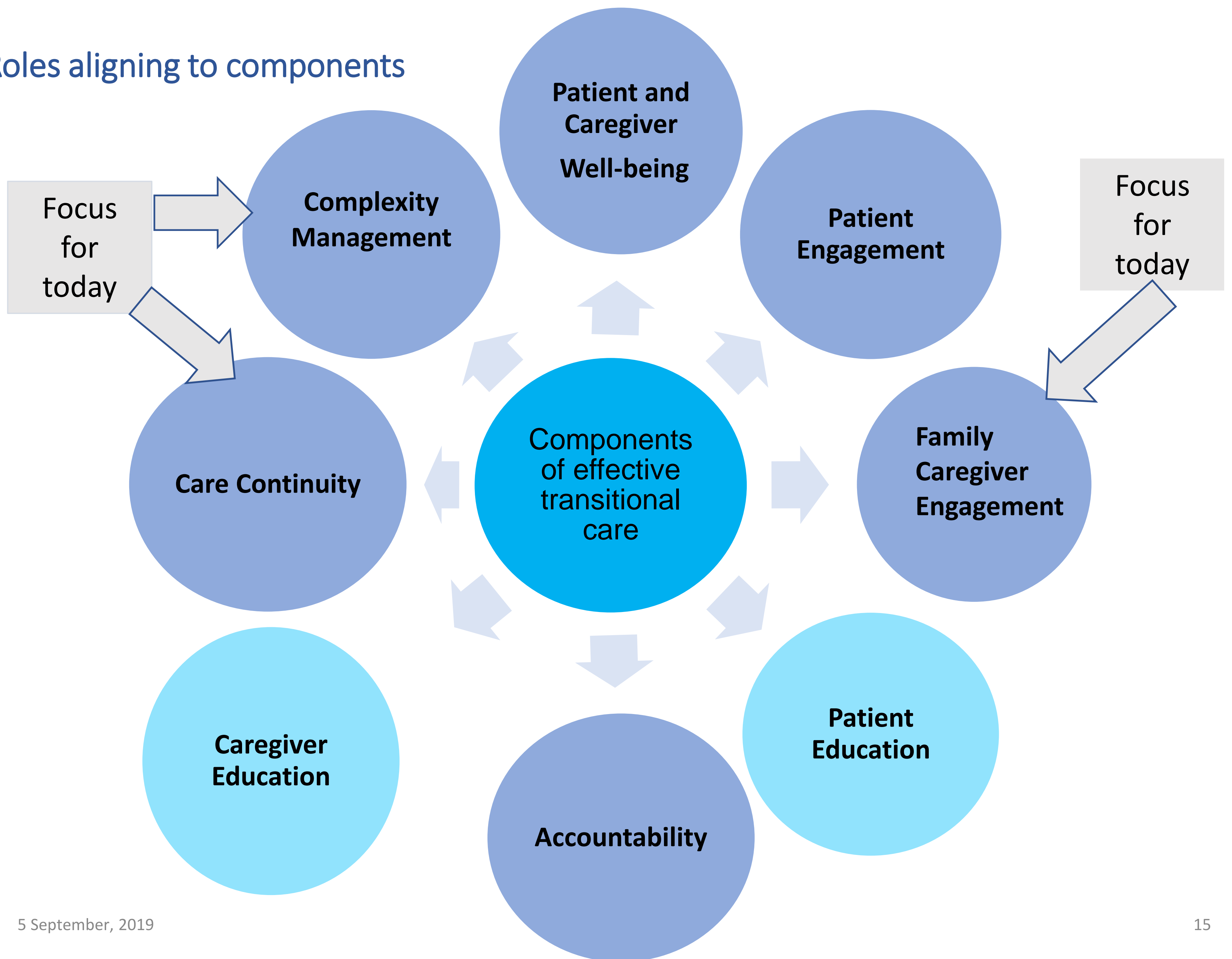


"I think our main thing is that if you do the admission assessment correctly it always facilitates a smooth discharge…if you can identify what the person's needs are when they come in…you can anticipate any changes during the process while they are here…. The questions at discharge I think should come up early on in the admission"
(Hospital nurse)

" Well, their biography, that's very important. If you send a resident without any details, they will struggle, the hospital also will struggle."

(Care home nurse)

2. Roles aligning to components



Complexity Management

Hospital nurses

"and for us it's about trying to facilitate a more early discharge if you possibly can, because we feel the longer they're in, moved from ward to ward, it causes more problems really"

"You have to think very specifically about what their needs are, um, you know, right down to things like, you know, falls management, …because, um, people with dementia don't do what you expect people to do, ..you just need to think of all those things and how you're going to manage it"

"it's our clinical judgement in how we want that patient to get safely… I mean there's no point if we've been enhanced supervision a patient in the hospital, there's no point us saying, we'll have a one person ambulance"

Naylor's definition

Achieving holistic person-centred care characterised by anticipation, prevention or early identification of problems. Medication management to ensure optimum therapeutic outcomes and reduction of adverse events.

Care home nurses

"People can arrive back confused, disorientated, they might have thought they were going home and not actually remember they live here, so that can be quite distressing, it's good to make sure there are staff around, if they know them quite well, to re-orientate them".

"So they come back and sometimes its hard to digest for everyone the person no more walks, swallows, no more eats normal food, major changes affecting their daily living…if they have major changes in there we have to go in and reassess them"

"It can often be confusing in terms of medication, this has been stopped on admission due to this reason, however the reason those medications have stopped that's been treated, but they are not on them now, has it really stopped? is it a mistake? so there's a lot of phone calls to just make sense of that"

Care continuity

Hospital nurses

"And then obviously if they were independent in the care home and then they've come to us and they're not walking at all, obviously we need to see if we can try and get them back to how they were……"

"….it's all about having those discussions, making sure that the information is passed across accurately, um it's important to have a verbal discussion if it's complex, and then back it up by the written information.. "

"say there's a lady that's got a new catheter, we would do that referral to the relevant agencies that need to deliver the products etc".

Naylor's definition

Management continuity: comprehensive implementation of individualised care plans and timely access to health and community services.
Information continuity: timely exchange of information between all team members.
Relational continuity: access to continuous sources of care to foster trust with patients and caregivers.

Care home nurses

"It's our responsibility to go through everything, read the discharge summary, hopefully that, and make sure all the meds are there on the discharge summary and everything and if they're not deal with it."

"We are using the red bag scheme, I am sure that has been mentioned, um so we send in all that information, the patient summary, the hospital passport, DNR, everything they might need, that goes with them"

"Sometimes we question whether things are appropriate or not with the GP…it may be something, an appointment that's not particularly crucial, and maybe it's a long distance away, and the distress that would cause with someone with dementia to go to that appointment, that might far outweigh the benefit of going there."

Family carer involvement

Hospital nurses

"A big part of what we do here, if we can, is involve families and things in the planning… any concerns we have got, changes to treatment or anything…."

"….sometimes we make phone calls, but often we try to talk to relatives face to face… but yeah just keeping them involved, it's such a worrying time for relatives, so yeah, keeping them up to date, with discharge plans. Are you happy with that?"

"Erm you know sometimes just having a familiar face around whilst you're, you know, we even encourage people if they wanted to, to come and escort their relative back. Can you go to the care home with them? It's amazing isn't it, how a familiar face can settle people sometimes."

Naylor's definition

Identifying what outcomes of care are most important to caregivers related to their role in caring for patients. They should assess their needs and capabilities, foster shared decision making related to plans of care; promote shared accountability for actions relating to care plans; and ensure respectful and reciprocal relationships.

Care home nurses

"A reason why the family want (admission to hospital) 'cause they see a treatment…the affect after the antibiotic course injection (Intra-venous antibiotics), you know, erm of course, the family think, I want my mum and dad to go there"

"We'll keep ringing the families to find out, how they are progressing… yeah if we don't get any information and family says, we visited Dad and he's not the same, then we feel, yeah, we need to get out for a reassessment."

"It's a stressful effect on them, it's a change, hospital to nursing home, so involving the families can help a lot in that condition… cos if the family is there… when they come back, they can see a familiar face…that can actually be supportive."

New components for this transition

Care home Engagement

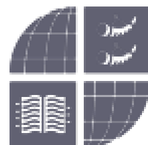
"it's a two way discussion really between the care home and us, as to what's best for that person"
(Hospital nurse)

"More often I get call asking about the person, their abilities prior to going into hospital. And that they will be discharging fairly soon."
(Care home nurse)

Care home Education

"It's just a bit of direction, instruction, it also depends on the level of skill at the nursing home, because there are different standards of homes
(Hospital nurse)

"So this person came with a new procedure, most of our nurses don't know, this was a new device, so we told them they need training for our staff and they have arranged it."
(Care home nurse)



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Discussion

Nurses in both settings perform multiple roles to ensure a quality transition.

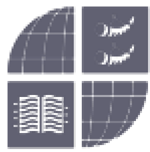
Nurses' roles align to some of the care components developed by Naylor and colleagues, although some require modification for this transition, and not all apply.

Two new care components for transition to a care home setting were identified which could be added to the framework.

Conclusion

Study findings can be used to inform:

- Future hospital and care home policies
- Nurse education curricula and staff training.



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thank you

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