Hospital at Home: Scoping report into dementia and care homes

Purpose and summary

- Assess the current state of hospital at home service care for people living with dementia.
- Identify good practice for how hospital at home services treat patients with dementia.
- Capture the current state of how hospital at home services work with care homes to treat their residents that experience an acute episode of care.
- Identify good practice for how hospital at home services treat residents in care homes.

Key findings

- Evidence demonstrates that hospital at home is the best model for treating instances of acute ill health experienced by people living with dementia or in care homes.
- There are significant cross-over between the two groups of patients, as there are many patients living with dementia who are also living in care homes. Both populations, and especially when combined, can be exceptionally frail, and have the most to lose by coming into the emergency department of a hospital.
- There are many actions that can be taken by hospital at home teams which have the potential to improve the experiences of patients with dementia or living in care homes.
- Nonetheless, there are also many connections and changes which need to be taken on the level of the wider health and care system to generate sustainable and significant improvements for these groups of patients.
- The support of hospital at home needs to be accompanied by support in the system, for example: memory or stress and distress clinics, care homes teams located in NHS boards, and the social care infrastructure.

Dementia

- Hospital at home services are well suited to treat patients with dementia. Completing cognitive assessments with every new referral is an important part of the patient pathway that all services should undertake.
- Whilst most hospital at home staff are well informed about the factors to consider for patients with dementia, there is scope for national programmes to support hospital at home services with training and education.
- Hospital at home evaluates positively for patients and family members, however the impact on carers is an important factor for delivering acute care at home. Carer fatigue can occur, and work may be needed to coordinate support at local and national level as more people receive acute care at home.
- Data on patients with dementia receiving hospital at home treatment is limited and there is no national dataset which can be interrogated to understand the impact on this patient group.

Care homes

- People living in care homes are likely to benefit from hospital at home care given the multi-morbidities and frailty of that demographic. In general, care homes demonstrate a willingness to work with hospital at home services, however frequent and consistent communication is needed to ensure the roles and responsibilities of care home staff and hospital at home services is clear.
- Escalation during a patient treatment episode is crucial to ensure that people are not transferred to hospital unless it is necessary. Hospital at home services have experience using communication tools, such as the Situation, Background, Assessment, Recommendation (SBAR) tool, to bring clarity to the patient pathway but there is opportunity to develop this further at local and national level.
- While much of the communication is handled at local level, there is an opportunity to address the issue of risk appetite and care planning at a national level by working with national organisations such as the care inspectorate.
- Future care planning is a crucial aspect of ensuring a patient's wishes are followed during a crisis. While recognising that hospital at home plays a limited role in the development of future care plans (given the short length of stay), there may be benefit in supporting services to share examples of what works.
- Data relating to hospital at home patients who are resident in a care home is available at a local level for some hospital at home services. However, there is no national data set that brings this intelligence together.
- Incorporation of care homes learning into hospital at home learning system.

Data

Data is not collected nationally to enable analysis of the impact of H@H on people living in care homes. However, using data shared by NHS boards on a one-off basis we have been able to determine that for the largest H@H services approximately 14-24% of the patients admitted to H@H

are resident in a care home. In terms of equity of access, analysis of care home addresses suggests that approximately 55% have access to H@H services.

Data is not collected nationally to enable analysis of the impact that H@H services have on people living with dementia.

Process

Summary based on semi-structured interviews with hospital at home staff across Scotland. Roles of interviewees include advanced nurse practitioners, clinical nurse managers, team leads, and clinical leads. Researcher used a list of up to 12 questions, though this was refined down after the initial interviews. Staff were generally familiar with both topic areas, so were asked questions on dementia and care homes within the same interview.

A scoping evidence review was conducted and is included in Appendix 1.

Dementia

Current state

Summary of hospital at home staff experience

The hospital at home staff we spoke to are positive that it is the best treatment option for patients living with dementia who meet their referral criteria. Staff promote and recommend hospital at home for people living with dementia wherever possible. There is a general understanding in healthcare and across other populations working and living with people with dementia, that moving them out of a familiar and comfortable environment is detrimental to their health and can result in rapid deterioration of the condition.

Families and carers often identify that their preference is for people living with dementia to be treated in the home. Staff mention that families are grateful for the service, which enables them to speak directly to clinicians providing treatment and care.

There is a significant amount of cross over between treating residents in care homes and people living with dementia. Staff agreed that care homes are well set up to manage dementia and shared very positive experiences and feedback around the quality-of-care people living with dementia receive in care homes. Their familiarity with the residents is beneficial, especially when hospital at home staff come to treat new patients, as care home staff can provide background on the patient, including their baseline function, mobility, and cognitive state.

How patients are currently assessed, tools available, referral pathway etc.

Working out prior cognition is part of a standard hospital at home assessment, and it is reportedly common to see a patient and discover they are experiencing cognitive decline. Teams will do different assessments to identify cognition, such as the mini-mental state examination (MMSE), Addenbrooke's cognitive examination (ACE), or the Montreal cognitive assessment (MOCA). Teams will usually refer onwards to a community mental health team (CMHT) or GP once they've identified cognitive issues. If there are services which support people living with dementia in the area – such as

memory clinics – they will usually take over from the hospital at home team once the patient has been treated and discharged.

Hospital at home teams diagnosing dementia have found that psychiatrists are willing to support their diagnosis without assessing the patient themselves, reducing delay to diagnosis and discharge. This can also assist with quicker referrals to relevant services in their area, highlighting the importance of effective referral pathways and the availability of specialist teams.

What works

While hospital at home staff were clear that they didn't need to adopt any specific or new approaches to support people living with dementia, there are some clear enablers to good care.

- **Treatment**: Patients comfortable at home, supported by an informed and motivated carer.
- **Staff**: Experience in treating people living with dementia, completed basic training modules, understand referral pathways, confident in taking a cognitive history and using cognitive assessment tools, ability to assess risk, and understand onwards referrals and support available in system.
- **System**: Support of specialist teams and medicine of the elderly consultants or geriatricians. Access to psychiatrists via CMHT. Support from social care as well as through the third sector, for patients and for carers.
- **Care homes**: If a patient is a resident in a care home, it is important to have clear planning and communication around hospitalisation, as well as the support of staff who are familiar with the patient's eating, sleeping, and movement patterns.

Areas for improvement by theme

Staffing/training

Staff were unaware of additional training in treating patients with dementia beyond the online modules relevant to their roles. The lack of hospital at home-specific training in dementia wasn't identified as a gap or deficit.

Less experienced staff will have to learn how to screen for any cognitive decline and possible undiagnosed dementia, which involves overcoming the initial barrier in communication that they might struggle with.

Patient experience and treatment

Staff emphasise that they treat patients living with dementia the same way as they would in hospital. Patients and carers were not consulted as part of this research, but the evidence shows that patients with dementia are better off when treated at home[6,15]. Staff report that patients feel more comfortable and are less likely to develop delirium.

Carer/family support

Caring for someone with the behavioural and psychological symptoms of dementia, or related stress, is demanding. This pressure can result in hospital admissions, as carers feel unable to cope with the demands. This was summarised as "it's not always about medical management; it's about such as carer strain and practical problems such as feeding and cleaning patients".

Due to carer fatigue or other reasons, people with dementia might have a fragile or limited home care system. This can affect hospital step down, which some hospital at home services provide. People living with dementia might end up bouncing between hospital and hospital at home services due to the families' inability to care for them.

Hospital at home teams can educate carers about dementia when treating patients, through sharing leaflets, explaining delirium, and practical advice for supporting the patient at home. Working with the social care support that is available can enable patients to remain at home for longer.

Referral pathways/connected working

The availability of local services and specialist input can vary between boards. Some areas have cognition, memory, or dementia teams, and services can generally call on the support of medicine of the elderly consultants or geriatricians. Areas without specialist services can find it more difficult to discharge patients once they have been stabilised.

Care homes

Current state

Benefits of hospital at home for care homes residents

In general, staff who took part in interviews were very positive about their interactions with care homes. They noted that, while every care home is different, they have been easy to work with. In some areas, staff spoke of having to put a lot of work into building relationships. Most reported that they felt residents were well supported in periods of ill health, and that everyone was working towards the same outcome. Care home staff are usually trained to look after patients and can inform hospital at home staff about the resident's needs and history. It was emphasised that it's important to remember that the care home staff aren't nurses and need support and encouragement from hospital at home staff when dealing with unwell residents.

Statement on variability

There is a lot of variation between homes, including nursing homes. Local authority funded homes were unanimously praised by staff in interviews. Private care homes are less uniform. Staff noted that there is fair amount of work in finding out what to expect from different homes – again, clear documentation and pathways can help mitigate variation. Council-run homes tend to have the best in-house support, knowledge and expertise, and have shared values and documentation with the NHS. In private homes, often the quality of care depends on the size of the company. In general, larger, national groups running a number of care homes might use more agency staff, be more inclined to send residents to hospitals when experiencing ill health (rather than using hospital at home) and be less receptive to developing pathways and understandings with hospital at home teams due to institutional inflexibility.

What works

An important factor that was raised by hospital at home staff is the need to be clear around the roles that the different entities play when supporting residents. There is a large amount of variation in how different services, care homes, and other services – such as GPs or pharmacies – operate, which means national approaches are not always possible. However, there are some clear themes.

- Care home nurses – in the care home or offered via an NHS care home team (such as in NHS Lothian) – can help with medical care on either side of a hospital at home visit, but the key role for the hospital at home team is to medically stabilise patient and initiate treatment.
- Hospital at home services who offer Outpatient parenteral antibiotic therapy (OPAT) services will have to be careful to manage the amount of resource they dedicate to it, otherwise they may be limited in the number of other types of acute adult patients they are able to flexibly support.
- Teams should be clear with care home staff that they don't need to contact the GP alongside the hospital at home team when a resident is receiving hospital at home care. This can result in unnecessary prescribing and can confuse residents.
- Hospital at home teams, by completing geriatric and frailty assessments can complete additional tests that a GP might want to do but not have the time for. This results in unnecessary medications being deprescribed and the patient receiving a comprehensive review. These assessments being carried out alongside the acute medical problem are a positive advertisement for the benefits of hospital at home and can help with building positive relationships with GPs.

In addition, hospital at home staff have highlighted several enablers to better working with care homes.

- In some areas, hospital at home teams are supported by an operations group with hospital at home staff, local GPs, and Scottish Ambulance Service; nursing home representatives are also invited to these meetings.
- Building connections with senior carers in the homes, and with care home staff more generally (through providing education and recognising good practice where it occurs) can build buy-in and encourage staff to follow care plans and future care planning.
- Sending care homes admission criteria, service information pamphlets, and other documentation helps to make the role of hospital at home clear.
- Doing teach-back exercises with staff can ensure that they understand care plans for residents.

Areas for improvement by theme

Communication and awareness raising

A challenge encountered by hospital at home teams when working with care homes are issues with communication. Sometimes this can be administrative – care home staff, especially nurses, can be hard to get hold of. Care home staff might not be able to communicate effectively around medical issues, or can struggle to provide key information, such as when the patient was last mobile or used the toilet. There is also poor communication across primary and secondary care, which can result in issues not being flagged or over prescribing. Communication around the role of hospital at home, squashing scepticism and building buy-in are also a challenge, which primarily can only be affected by showing how hospital at home better serves residents.

Staffing/training

Care homes' use of agency staff was also highlighted as a challenge for services. There is a high turnover of staff, they aren't always familiar with patients and shared language can be a problem.

This can result in care plans not being followed, or ambulances being called unnecessarily. Staff suggest being extremely clear with plans and language, providing training around using the SBAR format for reporting issues, and documenting decisions made around resident care and treatment.

In addition, some staff highlighted the importance of being approachable. Care home staff should be comfortable to approach hospital at home staff with questions. On-the-spot training by hospital at home staff is helpful to build capacity in care home staff, though the high turnover of staff can be a challenge to maintaining understanding. One nurse mentioned that they used to feel frustrated with care home staff, but have adopted a more positive attitude, focusing on a shared attitude emphasising the best possible care for patients.

Clinical and legal risk

One challenge is managing the varying appetites for risk held by different care homes. This risk can depend on the policies of the care home, whether they have medical staff in-house, and their willingness to risk litigation. Sending a resident to hospital in an ambulance can be seen as 'taking action', which can be reassuring for residents, family, and staff, even when they may be seen more quickly by hospital at home. It can also result in quicker access to medical professionals, such as paramedics, which can be helpful for homes without nurses. Some hospital at home staff suggested this doesn't result in time savings, as once the patient has waited for an ambulance, moved through the hospital, and finally started receiving treatment, hospital at home can offer similar timelines for treatment, with enhanced resident comfort. Hospital at home services do not operate over 24 hours, so out-of-hours, care homes are likely to call ambulances even when the patient's preference is to remain at home.

Pathways

Areas have various pathways in and out of care homes for hospital at home teams. Some teams provide step-down services to support patients transitioning out of hospital and back into their (care) homes. Sometimes this can lead to problems, as some homes limit the times in which patients can re-enter the homes due to lack of appropriate staff.

In other areas, dedicated care home or palliative care teams are available, and hospital at home teams can refer on to them for continued support once the patient has stabilised.

In general, there is more that can be done to highlight the validity of hospital at home as a provider of inpatient-level care to care home residents. Some long-established services noted that they still get referrals from new-to-them care homes, suggesting that the homes either weren't aware of or didn't fully trust hospital at home as a service.

Future care planning and care planning

Another challenge is around future care planning, including Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) documents. While hospital at home can have a role in initiating these discussions, the main role of the service is helping to implement the future care planning when the time comes.

There is a lot of variation in how GPs and care homes support residents to write anticipatory care plans. Staff noted that future care planning is a significant commitment, involving conversations with care homes, families, and residents. Hospital at home can be good at supporting patients to consider future care planning, however care home staff can't always be relied upon to follow plans. This is particularly relevant when a home uses a lot of agency or bank staff, who might not be familiar with

the resident. Staff noted that it is important that future care plans are extremely clear, as they will often need to be consulted at awkward times by night staff. Some staff mentioned that they go back to care homes to check whether they are using forms appropriately.

There is a lot of variation between boards as to what documents they expect and require – for example, NHS Borders doesn't use ReSPECT documents. Care homes can feel unable to support end of life care and may disregard future care planning. It is also important to ensure that staff understand the difference between different types of documents – a ReSPECT has a section for emergency care and treatment, including cardiopulmonary resuscitation (CPR), but this can't be accepted as a 'do not resuscitate' order.

Medication

Some teams highlighted a challenge around getting access to medication when prescribing for care home residents. Care homes in some areas can use large, centralised pharmacies, which make occasional bulk deliveries. This can result in a delay for patients waiting for medication.

Staff also highlighted issues with double or over-prescribing for care home residents, especially when homes involve GPs and the patient is also being seen by hospital at home.

Appendix 1

Scoping evidence review including bibliography

Hospital at home is supported by a robust evidence base, however there is limited evidence around the specific aims outlined above. A scoping search for each topic was completed using the terms hospital at home and virtual wards, alongside dementia plus cognitive decline, and care homes plus nursing homes. This was supported by additional grey literature searches on Google, and papers identified in the Healthcare Improvement Scotland Hospital at Home guiding principles for service development document. There is a comparatively good amount of literature around hospitalisation and dementia, and hospitalisation and care homes, with few specific mentions of hospital at home within these sources.

Across the literature, there is broad agreement that hospitalisation often results in worse outcomes for frail older (65+) adults[3,4,5,7,8,9,13,15] and the number of frail adults is on the rise[14]. Older adults also make up most of the hospital admissions across the UK; an article written in 2012 identified that "nearly two-thirds (65%) of people admitted to hospital are over 65 years old, and over the last 10 years there has been a 65% increase in the number of people aged over 75 who have required secondary care"[11].

These poor outcomes are particularly acute for patients who are hospitalised while experiencing cognitive impairment, such as delirium and dementia[1,3,5,6]. Older adults experience a higher chance of developing hospital acquired complications, which can lead to higher mortality and prolonged stays in hospital[5]. For people experiencing dementia, admission to hospital can significantly destabilise them, leading to longer periods spent in hospital or overall poorer health. The Alzheimer's Society, in their analysis of NHS England's Hospital Episode Statistics dataset 2012/13 to 2017/18, note the following: admissions of people with dementia had increased 35% between 2012/13 and 2017/18, that over 40,000 people with dementia were in hospital between a month and a year, and estimated that over half of people with a diagnosis of dementia in 2017/18 were admitted to hospital[2]. The Royal College of Psychiatrists identified that, in 2019, up to a quarter of all NHS England hospital beds were occupied by people with dementia, and that dementia was costing the UK economy £26.3 billion a year[10]. While this data is older, rising dementia rates[2] and the increasing hospitalisation of people with dementia means that these problems are still acute[12]. Hospitalisation while experiencing dementia is not only stressful for the patient, it can also be stressful for carers/families and hospital staff, with carers complaining "that healthcare staff do not recognise or understand dementia, that communication is poor, and that little stimulation is provided in hospital. Hospital staff report lack of training and that they struggle to deal with difficult behaviours and keeping patients safe"[6].

In our scoping search, a single source was identified which looked at acute outreach services to nursing homes, which has some relevance to the Scottish hospital at home context[8]. They identified that hospitalisation for older people living in nursing or care homes can put them at risk of losing their daily functional capacities, and that locating treatment in their (care or nursing) home can prevent delirium. The paper notes that patients and staff are more in favour of treatment at the home when compared to carers, suggesting that there may be issues around communicating the safety of hospital at home treatment.

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