



Australian and New Zealand Society for Geriatric Medicine

Position Statement No 18

Older persons in acute hospitals awaiting transfer to a residential aged care facility

Key Points

1. The decision to seek permanent residential care is of profound importance to older people and their families.
2. Such decisions are often made in hospital in the context of an acute medical illness from which there is incomplete recovery.
3. Decisions can be irreversible, as property may be sold, and motivation for independence may be lost.
4. Decisions should be made carefully drawing on a range of assessment and management capabilities, and avoiding undue haste, particularly early in the context of an acute health episode. Early and inaccurate decision making has the potential to create poor outcomes for older persons, and may interfere with operation of the health system as a whole.
5. The use of the terms “bed-blocker” and “acopia” should not be used in the clinical setting, as they contravene principles of human dignity, hinder the diagnosis and management of the problem that precipitated admission and increase the risk of inappropriate decision making, which may not be in the interests of the older person.
6. The decision-making process should have the following attributes:
 - a. There should be formal assessment of the person’s pre-morbid and current health, functional and social status; the person’s capacity to improve; and the family’s ability to provide care.
 - b. Assessment should commence early in the hospital stay, but decisions should be deferred until there is a high level of confidence of the requirement for residential care.
7. Hospitals and regional geriatric services should be sufficiently resourced to provide comprehensive geriatric assessment to all hospital wards.
 - c. Where there is capacity to improve, or there is uncertainty around such capacity, the person should be offered admission to a rehabilitation, geriatric evaluation and management program or other form of restorative program (such as, in Australia, the Transition Care Program).
 - d. In some cases, a protracted period of care may be acceptable, acknowledging both the consequences of the decision to the older person, and the high and continuing cost of permanent residential care to the community.
 - e. Assessments should be performed by health professionals, including a geriatrician, who have extensive knowledge and experience in aged care, including the prognosis and management of acute and chronic illnesses affecting the elderly, and the capacity of home care systems to provide alternative care.
 - f. The assessment process should be closely linked to, and preferably integrated with, the assessment process provided by the local aged care assessment service (in Australia, the Aged Care Assessment Team (ACAT)).

8. Where a local geriatrician is not available, arrangements should be established to link the assessment process to a geriatrician at a distance, using suitable e-health or telemedicine capabilities, supported by periodic outreach.
9. If a person is required to await a place in permanent residential care in hospital, a setting and care provision should be offered which facilitates preservation of cognitive and physical function and morale.
10. If an alternative care setting (an interim care facility) is used to accommodate a person awaiting permanent residential care, such a facility should be sufficiently resourced to ensure maintenance of function, and to facilitate discharge to a non-residential care setting should unexpected improvements in function or change of support availability arise.
11. Designated interim care facilities are not an appropriate substitute for rehabilitation or geriatric evaluation and management units and should not be created in a region unless adequate provision of these units is already established.

This position statement represents the views of the Australian and New Zealand Society for Geriatric Medicine. The preparation of this paper was coordinated by Prof Len Gray and Dr Lucy Dakin and was approved by the Federal Council of the ANZSGM on 4 May 2010.

Background paper

Introduction

In recent years there has been growing concern about older people who have been identified as requiring residential aged care (RAC) remaining in acute hospitals while they wait for placement in a suitable facility. This issue, often pejoratively termed "bed-blocking", has frequently been blamed for the restricted access to emergency and elective admissions in public hospitals (1). The background paper seeks to understand the phenomenon of "access and exit block" and to examine the complex interface between acute hospital care and residential aged care.

The Australasian population is ageing rapidly. Between 1988 and 2008 the percentage of the Australian population aged 65 years and over increased from 10.8% to 13.3%. In the next 30 years this proportion is expected to double (2). The situation in New Zealand is similar (3). Population ageing poses major challenges for the provision of acute and aged care to growing numbers of older people. Advancing age is associated with structural and functional deterioration in most physiological systems and an increased prevalence of chronic disease(4). Older age is associated with an increased risk of hospitalisation, functional decline and the need for permanent residential aged care (RAC) (5).

Older people are high users of hospital services. In 2004-5 people aged 65 years and over accounted for 35% of all Australian hospital separations and approximately half of all patient days (2). However, overall bed utilisation for this age group has fallen in the past 15 years. This is the result of disproportionate reductions in length of stay for over 75 year olds in spite of escalating separation rates (6).

Residential aged care admissions from hospital

The vast majority of older people admitted to hospital are discharged to their usual residence, which for most is their own home. In Australia during 2001-2 only 3.4% of live discharges of those aged 70 years or older were new admissions to RAC. Of these 2.4% were permanent admissions and 1% were for respite (7). Those discharged to RAC have a longer average length of stay than those discharged home (21 days compared with 5 days). Therefore whilst these individuals represent only a small proportion of older hospital users, they are of concern because they account for a disproportionate number of bed days. In April 2002 a cross-sectional survey of bed occupancy in Australian public hospitals was performed. It found that 1926 (12%) of 16,104 patients aged 65 years and older admitted overnight were considered by a member of the treating team (in most cases the senior nurse on the ward) to be more appropriately cared for in a residential aged care facility (8). Of these, 1306 were reported to have a current active ACAT approval for residential care, of which the majority were for high care. However, the study did not examine whether the health professional surveyed was appropriately qualified to make a judgement regarding need for RAC placement. Previous research has questioned the validity of subjective

opinion as an assessment method for inappropriate bed use (9).

This occurs on the background of a decline in recent years in the number of RAC places per 1000 of the population aged 70 years or older (from 90 places in 2004 to 88 places in 2006). This was the result of an Australian government policy response to public preference which aimed to substitute community aged care package places for residential beds (2).

In 2001-2, 57% of admissions to permanent RAC in Australia were transfers from hospital (10). Admissions to high level care accounted for the majority of these (83%). Thus the most common pathway into permanent RAC is via hospital. A common misperception is that this is inappropriate. The term "acopia" is frequently applied to this population with the implication that their problems are only of a 'social' nature and that there is no active or 'acute' medical problem (11). However studies have shown that older people identified as having "acopia" have at an increased risk of death and dependency (12). Older people awaiting RAC in hospital have more diagnoses recorded during their hospital stay reflecting higher levels of co-morbidity (4). One study of applicants to RAC identified an acute illness at the time of presentation in more than half of cases. In 9% this was the acute onset of a completely new disability, commonly a stroke. A further 46% of cases represented an acute episode of illness occurring on a background of chronic functional impairment (often dementia) which resulted in increased dependency beyond the threshold for institutionalisation (13). As the majority of patients assessed in hospital as requiring RAC have high care needs, often newly acquired, they cannot be discharged back to the community and must wait in hospital (14).

The nature of the decision to seek permanent residential aged care

The prospect of institutionalisation has been described as one of the most pervasive sources of anxiety in later life (15). The decision to pursue RAC has a profound impact on older people and their families. Leaving one's own home may be associated with a sense of loss of one's security, dignity, autonomy and competence (16). The decision to enter RAC, once made, is often irreversible as it may result in the sale of the older

person's property and disincentive to recover independence. Yet this life-changing decision is commonly made at a time of crisis, frequently in the setting of acute medical illness, and there is often pressure to make the decision quickly (4). How the decision is made may affect the older person's adjustment to RAC and their quality of life.

The capacity to improve outcomes

Functional decline is common among acutely hospitalised older people with studies reporting 30%–55% of individuals experiencing declines in activities of daily living (ADL), and up to 65% in mobility. As a result of this functional compromise, older adults may be unable to return to an independent living situation at the time of discharge from acute care and will be at risk of institutionalisation (17, 18). There is good evidence, however, that outcomes for acutely hospitalised older people can be improved with comprehensive geriatric assessment (CGA) and interventions aimed at restoring and preserving independence. CGA is a multi-disciplinary process focussed on determining an older person's physical, psychological and functional capacity in order to develop an integrated plan for management. CGA has been shown to improve functional recovery, reduce morbidity and attenuate demand for long term institutional care. It is considered the evidence-based standard of care for older inpatients (19). CGA can identify patients who may benefit from a longer period in hospital for restorative care and rehabilitation focussed on maximising functional recovery prior to discharge. CGA may be provided by consultancy services and dedicated assessment units (rehabilitation wards and geriatric evaluation and management units) and there is evidence to support the efficacy of both models(20).

The resources required for appropriate decision-making regarding RAC placement

If decision-making regarding RAC admission is to be both accurate and humane, all hospitals, regardless of size, should have access to a geriatric service. Geriatric services should be adequately resourced to provide comprehensive assessment of the older person's needs, access to restorative care and rehabilitation, information and counselling, and adequate time for decision-

making(21). Ideally these services should include a designated geriatric unit which offers programmes such as comprehensive inpatient assessment, rehabilitation and restorative care for patients with reversible functional impairment. Smaller hospitals may not have access to a full range of geriatric services but should have multidisciplinary team approach to assessment, rehabilitation and discharge planning and access to a geriatrician, who may provide an outreach service, either in person or via telemedicine (15). In Australia, the Transition Care Program should be accessed where appropriate. This program, which targets older persons at the conclusion of an acute hospital episode, provides flexible care in the form of a package of services that may include medical and nursing support, rehabilitative services, personal care and case management. The stated aims are to provide care that is goal-oriented, short term, therapy focused, and necessary to complete the care recipient's restorative process, and to prevent inappropriate admission to RAC by deferring a decision on entry until the older person's functional capacity has been optimised (22).

The costs of incorrect decision-making

Factors to be considered in the decision-making process include pre-morbid level of function, current health and functional status, level of social support, cognition and potential for functional recovery (11). Care must be taken to avoid transferring patients who, with appropriate rehabilitation and community supports, could potentially return home. Hasty decisions are likely to be inaccurate. Studies of recovery from severe disabling stroke suggest that whilst clinicians can, within 2 weeks of stroke, accurately predict walking ability and dexterity at 6 months, prediction of discharge destination and time taken to achieve maximal function tend to be poor. This is likely to be a factor of the heterogeneity of the recovery process, degree of patient motivation and the capacity of carers to provide for the person's needs at home (23). There is evidence that transferring older people prematurely to RAC can limit access to both aged care and acute hospital beds (24). Avoiding RAC admission in those with potential to improve increases the availability of RAC places for patients with no prospect of functional recovery for whom permanent RAC is the only option. This has the effect of reducing the

time spent in hospital waiting for a RAC place, which in turn improves access to acute hospital beds. Decisions made at the interface of acute and aged care therefore not only affect the lives of individual older persons and their families but also have the potential to impact the operation of both sectors. Where doubt regarding capacity to recover exists, older persons should be admitted to an inpatient rehabilitation unit, geriatric evaluation and management unit or other form of restorative program for further assessment and to allow time for maximal recovery.

The dynamics of the acute-aged care interface

The dynamics of the acute-aged care interface are complex. The time spent in hospital by older people waiting for a RAC place is dependent upon several variables including rates of hospital occupancy, the number of applicants to RAC and the rate at which permanent RAC places become vacant (14). Occupancy rates for both hospital and RAC are affected by the prevalence of disability in the population and by the capacity of formal and informal support systems to maintain older people in the community. The vacancy rate for RAC is a product of the total number of places and the rate of client turnover. Due to the nature of funding arrangements facilities tend to operate at very high occupancy rates. In Australia, for the period 2000 to 2005, occupancy rates remained stable at 95-96%. As a result, vacancies, particularly for high care, only occur when a resident dies. Any new vacancy is filled immediately. The pathway to permanent RAC can therefore be seen as a number of competing queues for limited places by applicants from the community, from hospital and from other RAC facilities. Hospital beds act as a buffer for those with high care needs that cannot be met immediately. At any one time, the number of hospital beds used in this way depends upon the degree to which demand for RAC places outstrips supply. Understanding the relationship between the hospital system, the community and residential aged care sector is vital if the issue of access-block in acute hospitals is to be addressed.

Summary

With appropriate geriatric management and rehabilitation, many acutely hospitalised patients with functional decline have the potential to regain independence and return home. Geriatric services

should be available to all and care should be taken to avoid hasty decisions about the need for RAC placement in the context of acute medical illness. However some hospitalised patients will have high care needs which cannot be met at the time of discharge from acute care. Given the limited supply of permanent RAC places available, acute hospitals sometimes have to act as a buffer for older people who are awaiting RAC and cannot be discharged to the community. An older person whose discharge is delayed should be cared for in an environment with adequate resources to maintain function and to facilitate discharge to the community should there be a change in the patient's condition or in availability of carer support.

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