Roca Rabionet, Claudia 2020 Adequation of Acute Geriatric Unit admissions in care home residents: can some be avoidable? *International Journal of Integrated Care, 21(S1)* : A166, pp. 1-8, DOI: doi.org/10.5334/ijic.ICIC20479

CONFERENCE ABSTRACT

Adequation of Acute Geriatric Unit admissions in care home residents: can some be avoidable?

ICIC20 Virtual Conference – September 2020

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Introduction

Adjusting hospital admissions of older patients is a pressing issue. Individualizing the most appropriate care setting for institutionalized patients is a challenge because of increasing levels of dependence, comorbidity, frailty and dementia they present.

With the purpose of adjusting advanced frailty patients' admissions and to increase the cooperation between the different healthcare settings, the aim of this study is to characterise patients from residential care admitted to an Acute Geriatric Unit (AGU), the benefit of the inpatient and examine the frequency and reasons for potentially avoidable hospitalizations.

Methods

A descriptive study of clinical and functional variables of admitted patients to the AGU in Hospital Universitari de Vic from nursing homes between January and September 2019. To early identify patients with clinical complexity, our territory has developed a tool that allows us to discern between complex chronic patients (PCC) and advanced chronic patients (MACA) and involves the elaboration of a shared therapeutic plan. To calculate the frailty score we have employed a cumulative deficit model index (fragil-VIG). The decision whether the admission appeared avoidable is by clinical judgment of the Geriatric team consultants according to the following criteria:

- Terminal patients in need of palliative care (PC) (not hospital procedures required).

- Patients that could have been directly referred to Intermediate care (IC) or to a hospital at home team (HHT).

- Patients in which a better management during a previous admission or by primary care could have prevented the admission.

Results

114 admissions were reviewed. The median age was 88,63 ± 5,8 years, 71,9% female, previous Barthel 40%, median IF-VIG 0,44, 76,3% have cognitive impairment. 13,2% identified as MACA, 55,3% PCC and 31,6% unidentified. A high number of patients' present polypharmacy (≥5 drugs) (82,5%). The average stay is 7 (1-14) days.

The most common presentations were: dyspnoea (37,7%) and falls (25,4%). The most common diagnoses at discharge: respiratory infection (22,8%), hip fracture (17,5%) and heart failure (17,5%). 45,6% presented delirium during hospital admission.

On discharge: Barthel 22,75%, 69,3% returned to nursing home but 17,7% with HHT support. 27,2% identified as MACA, 42,1% PCC and 18,4% unidentified. In 35.7% the level of care is described and in 78,9% drug prescription is adjusted.

Of the 114 hospital admissions 34 (30%) were considered avoidable. Main reasons: 35,3% could have been directly referred to IC, 5,9% to HHT and 23,5% were considered terminal patients in need of PC. In 29,4% multiple reasons to avoid hospitalisation were found.

Conclusions

Patients admitted to an AGU from nursing homes have frailty and dependence. Approx. 3/4 have cognitive impairment and polypharmacy. In-hospital death rate is high (14%). Hospital admission supposes an opportunity to increase the number of identified patients with clinical complexity, define the level of care and adjust drug prescription although entails the risk of functional decline.

Almost 1/3 of hospital admissions were considered avoidable. The main reasons were: directly admission to IC and need of prioritize PC strategies.

Improving integration between the different settings of care would allow a better adjustment of institutionalized patients admission.