

THE RISK FEEDING MODEL OF CARE: IMPACT ON LENGTH OF STAY AND READMISSIONS | Dharinee Hansjee & David G Smithard

Introduction

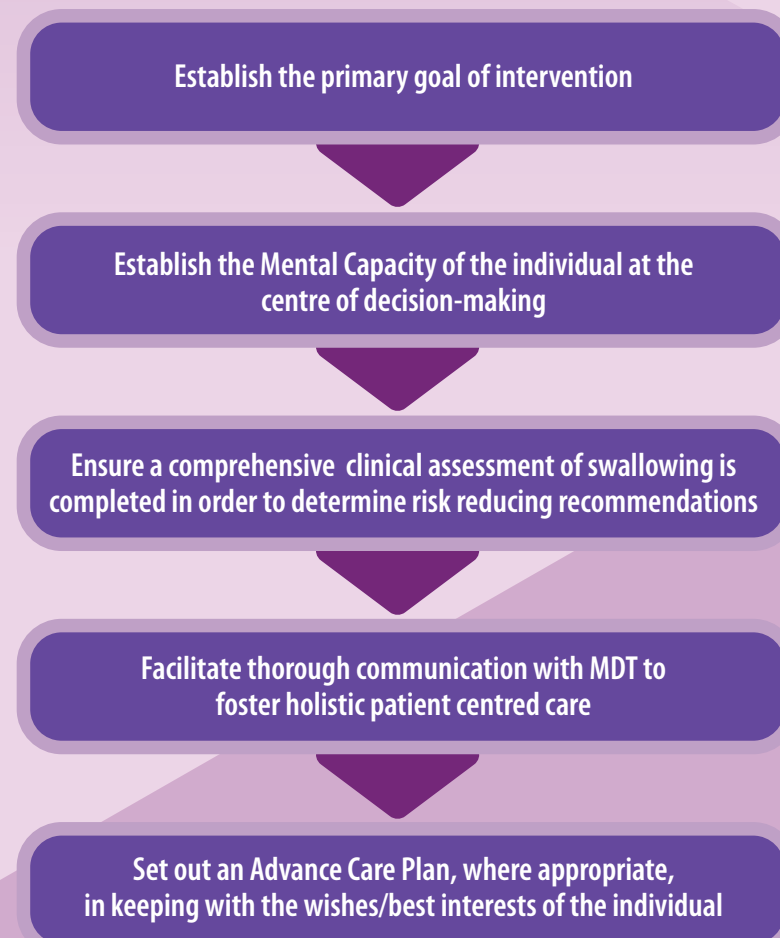
Swallowing difficulties are common in the frail elderly (Smithard 2016). According to a study looking at dementia in the acute setting, pneumonia was the principal cause of admission in 55% of the cohort (Cabre et al 2010). Extensive literature searching conducted on the management of nutrition in the frail elderly, evidences against tube feeding and proposes careful hand feeding (eating and drinking despite the risk of developing aspiration pneumonia) as being the preferred route of intake for this population group (Smith et al 2009; RCP 2010). Nutritional decisions at the end of life are ethically complex, particularly if the individual lacks decision-making capacity (Clarke et al 2015). The lack of guidance around decision making compromises quality and safety of care, resulting in poor patient outcomes and increased length of stay (Alzheimer's Society, 2009).

A protocol to guide decision making

In 2011, a risk feeding protocol was devised to bring clarity to these complex feeding decisions. A risk feeding protocol provides the multidisciplinary team with a person-centred framework to facilitate decisions on nutrition planning. The protocol outlines the reasons why a person may be a candidate for risk feeding. The document addresses capacity, quality of life and multidisciplinary discussions with the person/family. The management plan is authorised by the signatures of the consultant and the speech and language therapist. Risk reducing diet and fluid recommendations are also included to ensure the person is on the least distressing and least restrictive regime.



The risk feeding model of care is underpinned by the following guiding principles:



Purpose

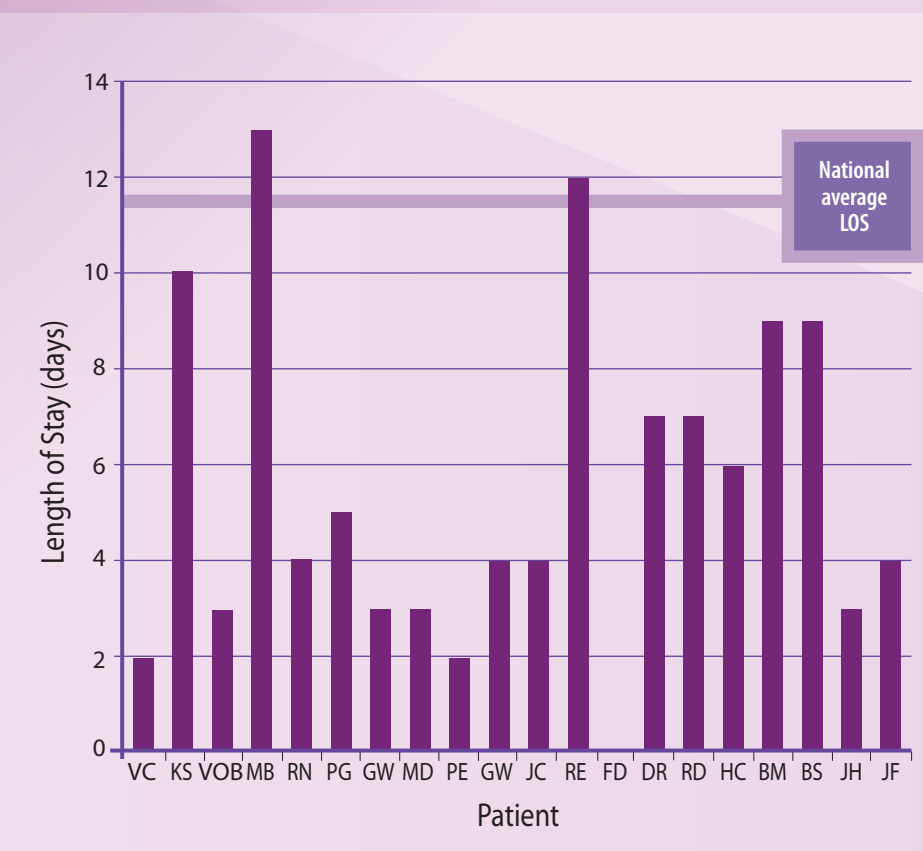
The average length of stay in hospitals for people with Dementia is 11.8 days with others ranging from 21.8 – 24.7 days (FOI request 2015, response from 73 Trusts, Alzheimer's Society). The purpose of this study was to investigate the length of stay of individuals with a diagnosis of dementia, who were admitted with aspiration pneumonia. Readmissions in this cohort, were tracked following the introduction of a multidisciplinary model of care to guide feeding decisions in the acute setting.

Methods

A review was conducted on patients managed under this model of care, with a diagnosis of dementia, between September 2016 to August 2017. There were 44 patients within this cohort. Of the 44 patients, 20 (45%) were admitted with aspiration pneumonia.

Results

Patients referred for a swallow assessment within a day of admission (75%) had risk feeding in place within an average of 2 days. The average length of stay for these patients was 5 days (0-13). For two patients, length of stay was over 11 days. These individuals had complex admissions with overriding medical conditions such as stroke and multiple sclerosis as well as dementia. Within this cohort, 15% avoided admission by being discharged from the Accident and Emergency department with a plan for risk feeding in the community. Although 15% were readmitted over the year; none of the readmissions were as a result of chest infections.



Conclusions



The application of the 5 principles promotes co-ordinated, collaborative working with multidisciplinary specific guidelines to ensure the team is working toward a common goal with the person at the centre.

By having a risk feeding model of care in place, this study evidences that the average length of stay can be reduced, potentially resulting in significant cost savings. The process facilitates a reduction in aspiration pneumonia re-admissions in the frail elderly, leading to a better quality of life for these individuals for a meaningful length of time.

References

Alzheimer's Society (2009). Counting the cost. Caring for people with dementia on hospital wards. London: Alzheimer's Society.
www.alzheimers.org.uk/download/downloads/id/2907/fix_dementia_care_-_hospitals.pdf

Cabre, M., Serra-Prat, M., Palomera, E., Almirall, J. and Pallares, R. (2010). Prevalence and prognostic implications of dysphagia in elderly patients with pneumonia. Age Ageing, 39, pp.39-45

Clarke G, Galbraith S, Woodward J, Holland A and Barclay S. Eating and drinking interventions for people at risk of lacking decision-making capacity: who decides and how? BMC Medical Ethics, 2015 16(1), 41.

Smith H A, Kindell J, Baldwin RC, Waterman D. and Makin A J. Swallowing problems and dementia in acute hospital settings: practical guidance for the management of dysphagia. Clinical Medicine, 2009 9(6), 544-548.

Smithard DG. Dysphagia: A Geriatric Giant? Medical Clinical Reviews. 2016; 2:5. doi: 10.21767/2471-299X.1000014

