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FOR THEIR SAKE

Can we improve the quality and safety of resident transfers from acute hospitals to residential aged care?

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Commissioned by the Aged Care Association Australia

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1 Table of Contents

2 Executive Summary

The interface between acute care and residential care of elderly people provides the ingredients for potential disagreement and circumstances which might impact negatively on the care of the residents and their families. In particular, the transfer of residents between acute care and aged care facilities has been the source of significant concerns within the aged care sector.

As a consequence of these concerns voiced by members of the Aged Care Association Australia (ACAA) a survey has been undertaken into the quality of service, continuity of care and duty of care around this important service interface.

The survey and this report document responses from 371 respondents from residential aged care facilities on their experiences in the chain of care between acute hospitals and aged care facilities. The Report provides comprehensive details of respondents input analysed on an issue by issue basis as well as geographically.

Unfortunately, responses by aged care personnel provide a worrying perception of hospital performance. These professionals have had reason to consult and collaborate with hospital staff in an effort to provide safe and effective care of residents moving between the two service industries.

The key issues addressed in the survey are summarised below.

- The **timing of transfer** of residents to aged care facilities leaves much to be desired. The perception gained by residents, families and aged care staff of hospital personnel involved with transfers is that many are discourteous and unconcerned with the comfort or safety of older people.
- There is a belief that hospitals are so desperate to get elderly people out of acute care that aged care personnel often doubt that **pre transfer preparations** have been carried out and that sometimes the patient is discharged merely to free up hospital beds.
- Often, on transfer, it would seem that **patient medical records and other documents do not exist** or that diligent records are not kept of the medical, nursing and other services received by patients. Without this basic information, not only are aged care professionals hampered in efforts to provide proper care, but also there may be life-threatening conditions which are not known on transfer.
- **Patients with mental illness comprise a special category of transfer** between acute and aged care facilities. On the one hand, there is evidence to suggest that in some cases patients are sedated prior to transport leaving them unsupervised and vulnerable at points in the transfer process. There are also allegations of discrimination by hospital staff against patients with mental illness and an inability to differentiate between dementia, mental illness, grief, delirium or normal cognitive decline. The unsupervised transport of such patients from hospitals to aged care facilities in taxis with no clear destination instructions creates further concern among aged care professionals who have experienced this situation.
- Prior to transfer from hospitals, aged care residents appear to suffer significantly from **nutritional deficiencies**. Mostly this involves severe weight loss by residents who go to hospital and this situation is exacerbated the longer the hospital stay. Problems here can include difficulty in getting food and drinks in the hospital environment; inappropriate food and food preparation and no feeding assistance for people with disability; no monitoring of food eaten or left by patients and sometimes the full plate is removed at the end of mealtime.
- Of all the clinical care issues contained in the problem categories surveyed, **compromised skin integrity** is the most widespread and a very disturbing issue. Reports of residents, who were previously without skin

problems, returning from a hospital stay with skin tears, decubitus ulcers on sacrum, heels and other bony prominences, and bruising from rough handling and other causes, are distressing to consider. Each of these people experiences pain and disfigurement arising from their wounds, as well as their emotional response to being treated in such a manner and not being able to protect themselves or take care of their own hygiene or wound care needs.

- There is a **low standard of hospital documentation** provided to aged care facilities on transfer. There may be a misunderstanding of legal requirements in documentation and who should have access; attitudes of hospitals staff which leads them to neglect documentation related to aged care; and reluctance of hospital staff to accept responsibility for accuracy and quality of documentation related to resident transfers.
- Unlike relationships between residents' families and aged care staff, respondents observed **relationships between families and hospital staff** as a disempowering and distressing experience. Families are reported to have been placed under pressure by hospital staff to quickly make life-changing decisions, or be bypassed in the decision-making process leaving them to live with the consequences. Technical details of treatment and legal requirements are often not well explained to families and when they observe the basic care needs of their relative being ignored by hospital staff, they find it very upsetting.
- Of all the problem categories covered in this report, **medication issues** relate directly to the credibility and competence of hospital medical staff. It is clear that many doctors do not understand the aged care industry, its services, or how it is set up, funded and accredited. Many of the problems arising from medical mismanagement of prescribed drugs for the aged care context have been suggested by respondents as relating to a lack of interest shown by many acute care doctors in aged care.

Each of these suppositions is addressed in the Report with detailed evidence to support the conclusions. A series of recommendations on the way forward is also proposed. These are summarised in the next section.

3 Recommendations

3.1 Timing of transfers of residents

The impression gained by residents, families and aged care staff of hospital personnel involved with transfers is that many are discourteous and unconcerned with the comfort or safety of older people whom they transfer away from their place of work. Comments in relation to a lack of professional respect emanating from hospitals imply a diminishing level of trust that professionals in the community and in aged care dare to hold about hospital personnel. Such views about the proficiency and diligence of hospital staff make it more difficult to meet due care responsibilities towards older people in this situation, and also to establish a mechanism that supports continuity of care that meets safety and quality standards.

3.1.1 Recommendations

Communication. Aged care and hospital leaders need to set up systems that standardise inter-agency communications around resident transfers. As part of this system, the logistics of transfers need close scrutiny and improvement in terms of timing of discharges; timing of communication; timing of transport; and codes of conduct for all personnel involved.

Policies and protocols. An inter-agency collaborative opportunity is needed to identify the causes of long delays in ambulance services; the prioritising of residents from aged care who are in hospital; and discharge policy monitoring so that remedial action can be taken as needed.

3.2 Coordination of transfers to allow preparation time

There is no doubt that coordination issues involving all partners in the resident transfer process are generating frustration and placing residents at risk of harm. The situation is not helped by perceptions that some hospital staff deliberately mislead aged care about essential work that may or may not have been completed prior to discharge just to move older people out of acute care.
Families also are perceived as not being treated well in their efforts to assist with coordination of transfers and instances of residents being sent to the family home rather than to the aged care home where they have been living, cast doubts on the skill and diligence of hospital staff involved.

3.2.1 Recommendations

Formal mechanism for service coordination. A joint committee involving hospital staff, aged care and ambulance staff as well as families needs to meet in the local aged care facility to discuss ways of ensuring that safety and quality aspects of resident transfers are met. Hospitals need also to monitor discharge practices of staff and take steps to provide inservice education if there is evidence of neglectful attitudes towards older people and residents of aged care homes.

3.3 Information on residents' condition prior to transfer

Reports on resident care and treatment are prominent documents in the professional approach to people requiring acute hospital services. It is difficult to imagine that these documents do not exist or that thorough records are not kept of the medical, nursing and other services received by patients. Yet this is the impression given by hospitals around Australia to the respondents in this survey. They have expressed concerns about the attitude of hospital staff towards older people; the veracity of their words and dealings with aged care providers; and the

competence of hospital staff in even the most basic of care and management tasks. It has even been suggested that the level of conscientiousness and professionalism of doctors and nurses in hospitals depends on the mood they are in at the time.

The consequences of such perceptions being held about hospital staff lie in the creation of an almost insurmountable hurdle preventing effective collaboration that would benefit older people who are in no position to adjudicate. When residents return home with drug-resistant infections, life-threatening conditions, no medications, no indications of care or treatment, and near death, the prospect of trying to locate a doctor or nurse who might be willing to talk to them, and who might know something about the resident, can be daunting for aged care staff.

3.3.1 Recommendations

Anticipate and prevent problems. Pre-discharge hospital visits allow aged care staff to gather accurate information and discuss care issues with staff who may know the resident.

Raise hospital awareness of aged care. Set up regular liaison meetings with ACAT and hospital staff.

Cost recovery. Estimate costs of aged care resources needed to compensate for hospital deficiencies and negotiate cost recovery arrangements with hospital management.

3.4 Appropriate management of mentally confused older people

On the issue of mental confusion and its management by hospital staff, half of the respondents do not have issues but the other half certainly do. Despite this division, the issues raised by those who do have experience of problems are quite disturbing to consider.

Essentially the major issue relates to perceptions of hospitals providing poor care such as routine use of physical and chemical restraint which strips residents of dignity and places them at greater risk of being neglected. The reported practice of sedating residents prior to transporting them in a relatively unsupervised situation to another place carries with it unwarranted risks to safety and general wellbeing.

The next area of concern is the practice observed by respondents of discrimination against aged care residents and older people with mental illness. It appears that hospital doctors and nurses and perhaps others do not have skills in differentiating between dementia, mental illness, grief, delirium or normal cognitive decline. As a result some older people are denied a valid working diagnosis and presumed to have dementia when this may not be so. Respondents also imply that once an erroneous diagnosis of dementia has been applied to an older person, hospital staff allow it to influence all future interactions with that person. Yet still some will send confused residents away from their hospital, in taxis and with no clear destination in some instances.

The other major concern is the mendacity of some hospital staff who have developed a reputation among many of the respondents for mishandling the truth about residents and their condition or prognosis in order to clear hospital beds.

Consequently aged care respondents' confidence in the psychogeriatric and mental health skills of hospital staff is as low as the confidence held regarding their basic clinical and management skills.

3.4.1 Recommendations

Restore trust. The most effective way to ensure residents move safely between services is to build care partnerships based on honesty and integrity. Any clinician who breaches this basic tenet of ethical conduct needs to be reported to the professional registration authorities who will investigate and discipline as appropriate. For the remaining ethical staff, efforts need to be made for them to become familiar with each others' environments so that greater understanding becomes possible.

Update psychogeriatric skills of hospital staff. With the demographic changes well underway towards an older population it is unacceptable for hospital staff to focus attention only on younger patients and avoid the health challenges faced by older people. Aged care staff are the experts in this area and could be available to update hospital doctors and nurses in approaches to mental confusion and assessment of causes.

Consult and collaborate on care of mentally confused people. A process could be set up where hospital clinicians could access advice from aged care on issues arising in the hospital context. Consultants from aged care could, at cost recovery, be made available to coach hospital clinicians in assessment and management of mental confusion.

3.5 Nutritional status of residents on arrival

Of all the problem categories examined in this report, nutritional status issues affect less than 40% of respondents and when problems occur they are spread across all locations. In fact 25% of comments received are quite positive about the way hospitals manage nutrition for older people in their care. In NSW particularly hospitals are undertaking focused strategies to improve the way nutritional status is assessed and problems addressed.

The issues that are reported by respondents mostly involve severe weight loss by residents who go to hospital and this is especially so the longer the hospital stay. In these instances the causes of weight loss can include difficulty in getting food and drinks in the hospital environment; inappropriate food and food preparation and no feeding assistance for people with disability; no monitoring of food eaten or left by patients and often the full plate is removed at the end of mealtime.

Some respondents commented on the lack of information provided to them about diet and nutrition arising from hospital dietician or speech pathologist assessments. In other instances some of the recommendations in these reports are somewhat unrealistic and quite expensive for families to purchase.

The issue of hospital staff competence was again raised under this problem category with respondents detecting their lack of interest in secondary conditions such as diabetes or dehydration and when a crisis point is reached, the remedy is intravenous replacement rather than ongoing assistance to drink fluids and prevent dehydration. The unethical behaviour of some hospital staff was also commented upon in terms of some clinicians telling families that aged care homes have caused the malnutrition and dehydration which developed during the hospital stay.

3.5.1 Recommendations

Improve communication. Assessments and reports conducted by dieticians and speech pathologists need to be shared with aged care homes. Some avenue is needed to allow follow-up communication and consultation with hospital based specialists as aged care planning gets underway. Where unethical behaviour is known to have occurred, aged care staff need to be able to lodge a formal complaint with the hospital as well as the professional registration authorities.

Evaluate basic nursing skills of hospital staff and update as necessary. Whether older people are being neglected because nurses are so busy or because they do not regard basic nursing tasks as part of their role, the consequences for older people can be measured in misery. Staff skill deficiencies need to be assessed and inservice provided as needed.

Trial the introduction of qualified care staff in hospital environments. If nurses are too busy to undertake basic care, their team could be augmented with qualified care staff as occurs successfully in aged care and other environments.

3.6 Skin integrity status of residents on arrival

Of all the clinical care issues contained in the problem categories surveyed, compromised skin integrity is the most widespread and a very disturbing issue. Reports of residents, who were previously without skin problems, returning from a hospital stay with skin tears, decubitus ulcers on sacrum, heels and other bony prominences, and bruising from rough handling and other causes, are distressing to consider. Each of these people experiences pain and disfigurement arising from their wounds, as well as their emotional response to being treated in such a manner and not being able to protect themselves or take care of their own hygiene or wound care needs.

Iatrogenic trauma and nosocomial illnesses are well known to hospitals and the evidence provided through this survey strongly supports the inclusion of skin breakdown as a result of the hospital environment, and trauma related to manual handling and other interventions, as measurable items under the International Classification of Diseases in hospital legal documentation.

Currently there seems to be little acknowledgement of these issues in clinical notes and respondents see no attempts at preventing trauma or even treating wounds when they occur. There is often no hospital acknowledgement of these wounds and bruises when residents return to aged care. In fact, respondents report an attitude of mendacity and blame emanating from the hospitals they encounter where some clinicians falsely accuse aged care homes of causing the wounds and even mislead families into blaming the aged care home. The reputation of some hospital clinicians is such that respondents have taken to photographing residents' prior to transferring them to hospital and again on their return in order to prove to families that care given prior to hospital admission was safe, effective and of high quality.

3.6.1 Recommendations

Work with hospitals to improve quality and safety for older patients. Aged care providers need to be able to feed into the quality and safety effort that should be occurring in hospitals so that unsafe and unethical behaviour of hospital clinicians can be reported and dealt with appropriately.

Cost recovery for iatrogenic and nosocomial problems transferred to aged care and families should be invoiced back to the hospital responsible for wounds, infections and mental distress caused to residents during hospital stays.

Introduce qualified care staff to work with hospital clinicians. Care staff could focus on the general needs of older patients and reduce damage that can arise from neglect.

3.7 Documentation related to treatment prior to transfer

Most respondents to this survey have experienced problems in discovering what may have occurred to residents while they were in hospital. A major issue is the poor quality of documentation received, if it is received at all, relating to

inaccuracies, inconsistencies on important treatment orders, illegible writing and faxed copies, confusing and unrealistic recommendations and no indication as to how these matters can easily be followed up.

The reasons for such low standards of hospital documentation are believed by respondents to be associated with a misunderstanding of legal requirements in documentation and who should have access; attitudes of hospitals staff which leads them to neglect documentation related to aged care; and reluctance of hospital staff to accept responsibility for accuracy and quality of documentation related to resident transfers.

Consequences related to issues outlined above include hurdles to delivering continuity of care and treatment as well as planning strategies to prevent a repeat of problems which led to hospital admission.

3.7.1 Recommendations

Improve hospital documentation systems. As part of a joint quality improvement committee aged care and hospital staff could devise appropriate documentation and transfer systems to overcome obvious flaws in current arrangements and meet the needs of both services.

Establish a hospital contact person who would be able to follow-up on documentation deficiencies without aged care staff having to divert resources to searching for clinicians and obtaining copies of basic information.

3.8 Information provided to residents' families prior to transfer

While around half of respondents surveyed have problems in this area, only one third volunteered comments about the difficulties they have experienced. Most comments relate to the nature of relationships between families and aged care services and with hospitals as well as relationships between hospitals and aged care.

Trust relationships between families and RACFs are built up over time and based on empathy, emotional and other support and the supply of information and skills coaching to help them deal with the long-term and sometimes harrowing experience of supporting a loved one in care.

Respondents tried to characterise the relationship they observe between families and hospital staff. Mostly they see it as a disempowering and distressing experience for families who can be placed under pressure by hospital staff to quickly make life-changing decisions, or be bypassed in the decision-making process leaving them to live with the consequences. Technical details of treatment and legal requirements are not well explained to families and when they observe the basic care needs of their relative being ignored by hospital staff, they find it very upsetting.

The relationship between these few hospitals and local aged care providers appears to be plagued with difficulties arising from ethical concerns about hospital practices that over 100 respondents have encountered in different States. Contested practices include hospital staff fostering complaints to be made about aged care homes; trouble-making comments urging families to take a poor view of aged care services; creating unrealistic expectations about what aged care can offer or achieve; making disparaging remarks about aged care without being informed about the industry or giving due consideration to the harm they may be causing to families and colleagues working in aged care. On top of these poor practices, some respondents believe these few hospital clinicians adopt such strategies because they are covert about their low standards and use legal hurdles to protect themselves from discovery.

3.8.1 Recommendations

Introduce a similar system of accreditation that currently applies to aged care. If outcome standards could be devised, based on hospital standards and principles of good practice as has been used in this survey, pockets of poor practice would be able to be identified and dealt with.

Support developments of alternative access to medical services. Hospital at home and outreach services from hospitals are less disruptive to older people and families. These could be extended more comprehensively into retirement villages and aged care homes while remaining the financial and medical responsibility of the State hospital sector.

Report episodes of unethical behaviour. Many of the shoddy behaviours identified by some respondents are unscrupulous and have no place in professional practice. Instances of professional misconduct need to be reported to registering authorities and disciplinary action taken as necessary.

3.9 Medication regime prescribed prior to transfer

Of all the problem categories covered in this report, medication issues relate directly to the credibility and competence of hospital medical staff. With so many respondents identifying this as a major problem for residents and families and for them as they attempt to take over resident medical care, it is important to think about the extent of the problem and what may be causing it to occur.

It is clear that many doctors do not understand the aged care industry, its services, how it is set up, funded and accredited. Many of the problems arising from medical mismanagement of prescribed drugs for the aged care context may well relate to a perceived lack of interest shown by many doctors in aged care. For instance, by not understanding the operational constraints of aged care, prescriptions that may be acceptable in hospitals become invalid out in the community where they need to be filled. Some respondents have commented as well on an apparent reluctance of some hospital doctors to get involved with non-hospital personnel in devising and planning care.

Supply issues also relate to medical lack of information about timing of discharges so that pharmacy supplies are available; or understanding who pays for the drugs under certain circumstances decided by the prescribing doctor. Safe prescribing is also an issue when changes are not explained to the general practitioner taking over the case; or where medication orders are illegibly written and inconsistent within the same documentation. The form of drug prescribed can also be unrealistic in an aged care home where there may be no registered nurse to perform the procedure and monitor for adverse effects and reactions.

3.9.1 Recommendations

Facilitate communication between doctors and pharmacists. Some effort is needed by aged care staff to bring these episodic care providers together on issues of safety and quality. Medical Advisory Committees could be one option but a similar effort is needed to ensure hospital quality and safety concerns are voiced and remedied.

Formal collaborative links between hospitals and aged care. A formal mechanism is needed for reporting medication prescribing errors and to follow-up on inconsistencies in medical orders.

3.10 Operational elements and inter-organisational agreements

There is no guarantee that agreements either formal or informal, on outcomes or targets, will improve quality and safety for residents. However the feedback received in this survey indicates that having no agreement at all does leave the situation open to problems that may not be identified or resolved as quickly as when an agreed position has been reached on key issues. It is possible for organisations working toward similar goals in care and service and for a similar clientele, to reach agreement on processes and protocols that can be monitored and reviewed.

3.10.1 Recommendations

Establish formal agreements between RACFs and hospitals. The template recommended by AHMAC could be used as a starting point for discussion and the issues identified through this survey could contribute to setting up outcome targets as well as mechanisms for close liaison and quality improvement.

Improve system transparency. More transparent and accountable protocols and policies need to be constructed around the joint interests of hospitals and RACFs as they work towards safer and more effective ways to transfer residents to and from services.

Cost-sharing arrangements. Investigate the possibility of sharing costs associated with assisting hospitals to improve their quality systems. Once a system is set up to acknowledge and compensate for expenditure associated with the care partnership, factors such as who pays for iatrogenic and nosocomial health costs for residents can be considered.

3.11 Overall Summary and Recommendations

Aged care providers work to achieve compliance with quality principles as expressed in 44 outcomes themed under four broad standards covering management, care, environment and lifestyle. All outcomes must be met and audited in order to meet accreditation requirements and continue to receive government funding. It is not unrealistic to expect other services providing services to older people to apply themselves to achieving similar quality outcomes for their service. Hospitals are increasingly involved with acute care and treatment of older people as well as providing the primary access pathway for people wishing to enter residential aged care. Perhaps it is time for quality standards to be introduced across the care continuum so that all involved are accountable.

Three major statements of standards and principles for hospital involvement with older patients and residential care clients were published in 2004 and provide a solid basis for comparison of standards of care, management and quality performance. These three reports have been applied in this survey to gauge the quality of care being provided by hospitals to residents while in hospital and during transfers.

The views of 371 senior respondents from aged care provide a type of report-card on hospitals they have dealt with … and the report is quite damning. Only with considerable effort and optimism has it been possible to extract positive interpretations for each of the statements or standards.

Some States are performing better than others and in NSW this is the case across most of the standards chosen. However views altered with different locations as they did for all States, and it would be wise for hospitals in these locations to listen to this feedback from a significant client group of their service.

3.11.1 Recommendations

Aged care standards apply to all who care for older people. Hospitals undergo management-focused accreditation however hospital care standards revealed through this survey need urgent attention and could benefit from participating in quality reviews aligned with aged care, particularly Standards 1 and 2 under the Commonwealth Aged Care Act 1997.

The results of this survey be used at State and local regional level to prompt greater communication and closer liaison between hospitals and aged care providers.

4 Survey background and demographics

4.1 Background to Aged Care Association Australia survey

In response to concerns expressed by members in relation to resident transfers, this survey has been commissioned by the Aged Care Association Australia Ltd to enable the aged care industry to better understand the nature of working relationships between acute hospitals and the aged care industry. Member issues and concerns include anecdotal accounts of inappropriate transfers in terms of the quality of service, continuity of care and duty of care related to the transfer of residents from hospital to residential aged care services.

The survey is structured around published public health system statements on standards and principles guiding hospital services to older people and also ACAA members' expressed areas of concern about hospital transfer issues.

This report of survey results will be used to inform the aged care industry about areas of concern in our relationship with hospitals and also provide a basis upon which it will be possible to identify strategies that work well. It is hoped that this report will be used to promote a productive relationship between aged care providers and the hospital sector so that residents will be safe and comfortable as they transfer between hospitals and residential aged care facilities (RACF) and the quality of life able to be experienced in their aged care home will be protected.

4.1.1 Survey participants

By participating in this survey respondents agreed to have the information they provided included in the analysis of the data. Respondents were not identified at any time during the survey, nor is their organisation able to be identified from the information provided. In all, 371 fully completed questionnaires were received by the end of the survey period. Participants were at liberty to withdraw from the survey at any time without prejudice and in fact, 64 people logged onto the electronic survey and opted not to continue. These incomplete responses, and a further six late submissions of completed surveys, have not been included in the analysis of responses.

All information provided in this survey will continue to be treated confidentially and stored in a secure location where only the researcher, Professor Tracey McDonald of Australian Catholic University (ACU National) will have access to it. Anonymity and confidentiality of all participants and organisations who responded to the survey is assured. Assurances were also given that conference presentations and publications arising from the survey will not identify participants or participating organisations and aggregate results only will be published.

The survey was themed under topic areas related to resident transfers between hospitals and residential aged care homes. These themes were evident in concerns voiced by ACAA members prior to the survey and as such, established a framework for inquiry.

4.1.2 Structure of report

The report is presented along the theme areas surveyed, showing overall results across a national sample and then presenting the results based on participating States.

4.1.3 Issues related to online survey approach

Because of the wide distribution of the survey and online access for participants, it is not possible to determine the exact distributional spread and therefore to calculate the sample size in relation to the total recipients of the survey, and by this means determine a clear response rate. The survey was circulated

electronically through the Aged Care Australia (ACAA) national office and then through each of the member states of ACAA. A rough estimate would be that around 1,000 organisations received the survey with an invitation to participate either online or by facsimile. Around 300 of these recipients would not have been involved in providing direct resident services and therefore would not have been interested in responding. If the remaining 700 service organisations were to be used for calculating the response rate, it would be approximately 55%. However because we have no way of confirming who received the circulated email survey, we cannot be confident in this regard. 64 respondents commenced the online survey but did not complete it, and there is no way of determining whether they stopped because they were in no position to answer questions about the issues raised; or whether they simply decided they did not want to continue.

A further issue arose with some respondents who miss-faxed their replies to a private number in Western Australia because they forgot to include a state STD code. The person in Western Australia reported that around 15 faxes had been received and destroyed before she eventually telephoned the researcher and asked that something be done to stop this occurring. Further, despite the completion date for survey responses being clearly shown on the front page of the survey, 6 responses were received after that date and were not included in the survey analysis.

4.2 Respondent profile

The 371 respondents from residential aged care facilities (RACFs) are mostly directors of nursing (DoN) or Directors of Care (DoC) who represent 59.57% of responses. The next largest group are registered nurses (RN) in supervisor or management positions 17.79% while chief executive officers (CEO) and their deputies (DCEO) representing 10.25% of the total.

Responses were received from all States however because only three were received from Tasmania, these have been incorporated into the Victorian profile to ensure that these Tasmanian organisations cannot be identified. No responses were received from Northern Territory or the Australian Capital Territory.

Respondents are fairly evenly spread across different geographic locations with the largest group (37%) being from large metropolitan centres. The next largest group (26%) are in the outer suburbs of cities, followed by large regional centres (20%) and small towns or villages (17%).

The most commonly reported aged care service level or combination of services is that of both high and low care residents (43%) with high care residents only (28%) forming the next largest group of respondents' organisations. Three level RACFs with high, low and independent living units generated 16% of respondents. Only 6% are from facilities with low care only and only 7% claim to have a combination of high and low care, independent living units and community aged care packages.

In terms of aged care industry sector participation, the largest group of participants (58.49%) are funded as church and charitable operators while the remaining 41.51% are private operators. Interestingly the pattern of responses in terms of geographic distribution by aged care industry sector shows that in metropolitan areas both sectors are similarly represented, but in the regions (76.37%) and small towns (73.44%), the majority of responses were received from organisations in the Church and Charitable sector.

Respondents to this survey are drawn from a range of aged care service sizes however the most common (32.35%) is between 61 and 100 beds. The next largest group (26.95%) are the 41 to 60 bed homes; and those under 40 beds (18.87%) account for the third largest group of respondents.

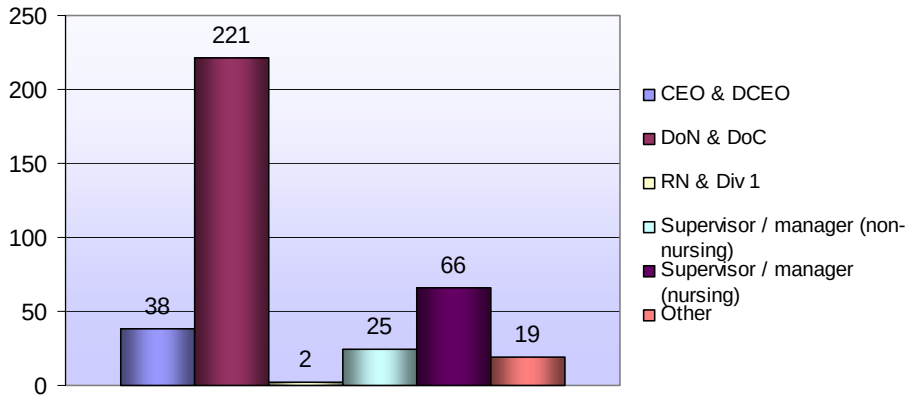
4.2.1 Organisational position of respondents

Of the 441 people who made some contact in relation to completing the survey, the 371 respondents included in the analysis are mostly directors of nursing (DoN) or Directors of Care (DoC) who represent 59.57% of responses. The next largest group are registered nurses (RN) in supervisor or management positions 17.8% with chief executive officers (CEO) and their deputies (DCEO) representing 10.25% of the total.

Table 1 Organisational position of respondents

	Responses	%
Chief Executive Officer	35	9.43
Deputy Chief Executive Officer	3	0.81
Director of Care / Director of Nursing	221	59.57
Supervisor / manager (non-nursing)	25	6.74
Supervisor / manager (nursing)	66	17.79
Educator or trainer	1	0.27
Allied Health professional	0	0.00
Registered nurse (Div 1 in Victoria) in mostly clinical role	2	0.54
Registered nurse (Div 1 in Victoria) in mostly management role	4	1.08
Medical practitioner / Nurse practitioner	1	0.27
Enrolled nurse (Div 2 in Victoria) in mostly clinical role	0	0.00
Enrolled nurse (Div 2 in Victoria) in mostly management role	1	0.27
Certificate 4 care worker – however named	0	0.00
Certificate 3 care worker – however named	0	0.00
Other	12	3.23
Total Answers:	371	100.00

Organisational position of respondents



Respondents in the 3.23% 'Other' category are comprised of therapists and other allied health professionals

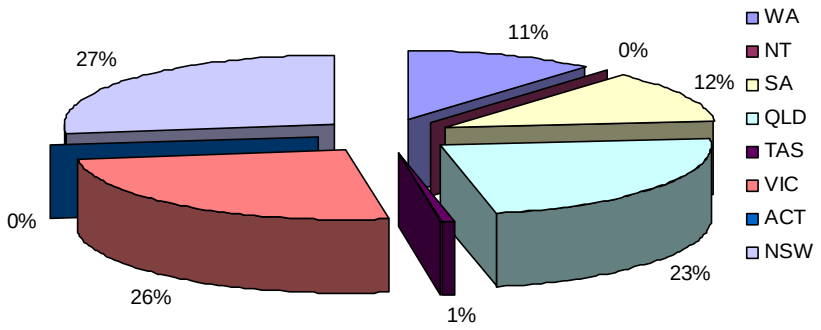
4.2.2 Statewide distribution of respondents

Responses were received from all States however no responses were received from Northern Territory (NT) or the Australian Capital Territory (ACT). In Tasmania only three responses were received and these have been incorporated into the Victorian profile to ensure that Tasmanian organisations cannot be identified.

Table 2 Statewide distribution of respondents

	Responses	%
Western Australia	42	11.32
Northern Territory	-	-
South Australia	45	12.13
Queensland	86	23.18
Tasmania	3	0.81
Victoria	95	25.61
Australian Capital Territory	-	-
New South Wales	100	26.95
Total Answers:	371	100.00

Statewide distribution of respondents



Respondents are fairly evenly spread across different geographic locations with the largest group (36%) being large metropolitan centres. The next largest group (26%) are in the outer suburbs of cities, followed by large regional centres (20%) and small towns or villages (17%).

4.2.3 Location of respondents' aged care facilities

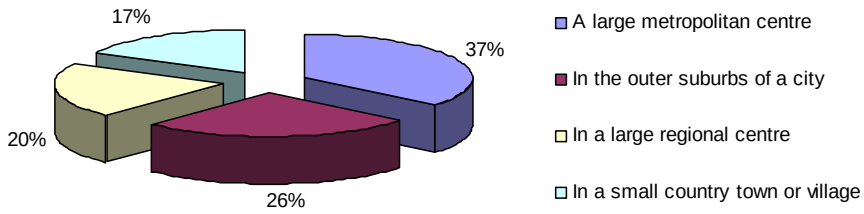
Table 3 Location of respondents' aged care facilities

	Responses	%
A large metropolitan centre	133	35.84
In the outer suburbs of a city	98	26.42
In a large regional centre	76	20.49
In a small country town or village	64	17.25
Total Answers:	371	100.00

Differences in location of aged care facilities may have some effect on whether they are able to access hospital services and also the level of service they may receive. The distribution of respondents in this regard causes a fairly even spread across metropolitan and regional centres which provides a certain amount of confidence that their responses and qualitative aspects of the survey can be taken as being relatively representative of the aged care industry.

Of course, with a sample size of 371 respondents, any statistical generalisations across all aged care homes would not be possible. Even so, in an industry of around 3,900 aged care providers, these respondents can be said to represent around 10% of the aged care industry.

Location of respondents' aged care facilities



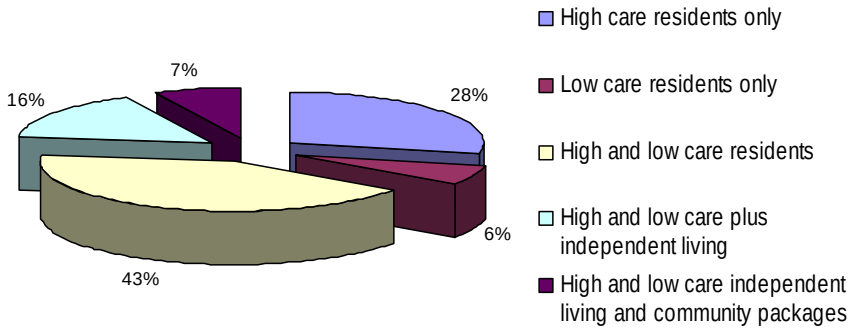
4.2.4 Service level of respondents' organisations

The table and chart shown below shows that the most commonly reported service level or combination of services is that of both high and low care residents (42%) with high care residents only (28%) forming the next largest group of respondents' organisations. RACFs with high, low and independent living units generated 16% of respondents. Only 6% are from facilities with low care only and only 7% claim to have high and low care, independent living units while also providing community aged care packages.

Table 4 Service level of respondents' organisations

	Responses	%
High care residents only	105	28.3
Low care residents only	24	6.47
High and low care residents	156	42.05
High and low care plus independent living	59	15.9
High and low care, independent living, community care packages	27	7.28
Total Answers:	371	100.00

Service level of respondents' organisations



4.2.5 Aged Care Industry Sector

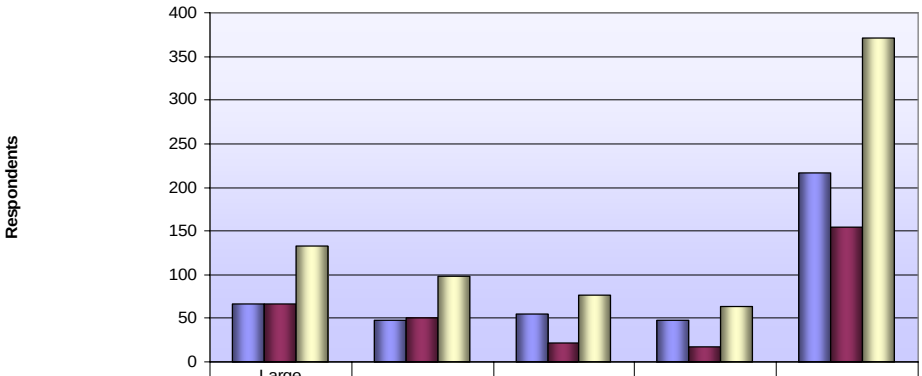
In terms of aged care industry sector participation, the largest group of participants 58.49% (*n*=217) are funded as church and charitable operators while 41.51% (*n*=154) are private operators.

Table 5 Aged Care Industry Sector

	Responses	%
Church & Charitable Sector operator	217	58.49
Private Sector operator	154	41.51
Total Answers:	371	100.00

Interestingly the pattern of responses in terms of geographic distribution by aged care industry sector shows that in metropolitan areas both sectors are similarly represented, while in the regions (76.37%) and small towns (73.44%), the majority of responses were received from organisations in the Church and Charitable aged care sector.

Geographic distribution of responses by aged care industry sector



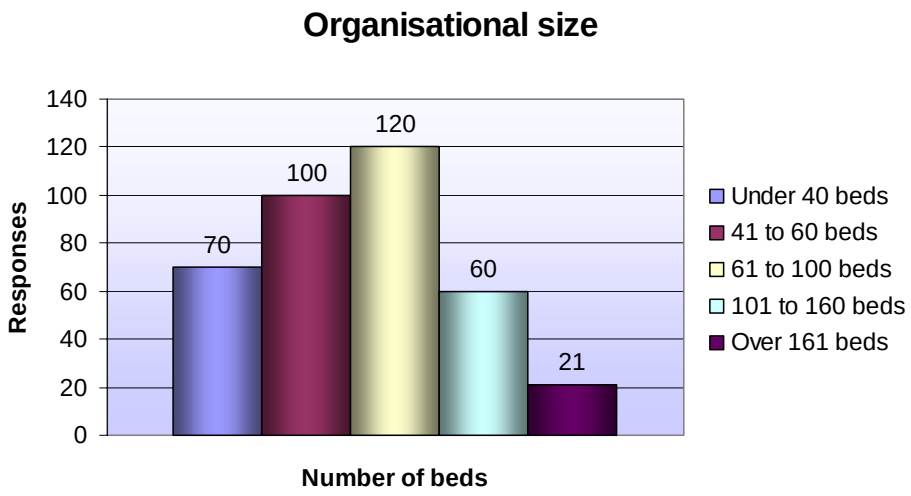
	Large metropolitan	Suburbs	Regional centre	Small town	Total
Church & Chairtable	67	48	55	47	217
Private Operator	66	50	21	17	154
Total	133	98	76	64	371

4.2.6 Organisational size of respondents' facilities

Respondents were drawn from a range of aged care service sizes however most commonly (32.35%) respondents are drawn from RACFs with between 61 and 100 beds. The next largest group (26.95%) are 41 to 60 bed homes; and those under 40 beds (18.87%) account for the third largest group of respondents.

Table 6 Organisational size of respondents' facilities

	Responses	%
Under 40 beds	70	18.87
41 to 60 beds	100	26.95
61 to 100 beds	120	32.35
101 to 160 beds	60	16.17
Over 161 beds	21	5.66
Total Answers:	371	100.00



The profile provided above is based on the responses of 371 senior people working in the aged care industry across Australia, in all levels of care services, and across both private and church and charitable sectors. The sample is representative of Church and Charitable as well as Private Operators in aged care. As well, the care level of participating organisations covers the full range of services across Australia. On that basis and considering the size of the sample, it is reasonable to regard the results of this survey as indicative of the aged care industry however there are, within the sample, wide variations reported on all variables.

The purpose of the survey is to investigate whether the concerns expressed by members about resident transfers are widespread, and the survey certainly demonstrates the extent to which these problems are being experienced by a wide range of service providers across all care levels and in most geographic areas.

5 Issues experienced by aged care staff in relation to transfers

The many anecdotal reports of difficulties and problems encountered by people working in the aged care industry in relation to receiving residents back to the RACF following a period of hospitalisation, prompted Aged Care Association (ACAA) to act on concerns that residents are being placed at risk. As part of their concerns about resident safety and welfare, aged care operators are also worried that their efforts to meet duty of care responsibilities could be undermined by poor resident transfer processes emanating from acute hospitals.

Major issues derived from anecdotal reports received before the survey, provided themes for survey respondents to consider in terms of whether they too had had experiences with similar situations. These themes are:

1. Timing of transfers of residents from hospital to your facility
2. Coordination of transfers to allow time for preparation for resident arrival
3. Information on residents' condition prior to accepting the transfer
4. Appropriate management of mentally confused older people prior to transfer to your facility
5. Nutritional status of residents on arrival at your facility
6. Skin integrity status of residents on arrival at your facility
7. Documentation related to medical and nursing treatment prior to transfer to your facility
8. Information provided by acute care personnel to residents' families prior to their return Medication regime prescribed prior to transfer to your facility

Responses from across Australia leave little doubt that these issues are being experienced in relation to resident transfers from hospital to RACFs with some problems clearly occurring more frequently than others. Respondents were asked to select from the list, areas of resident care and management that best reflect their recent experiences with resident transfers from acute hospitals to their aged care home. Most of the responses included multiple answers and very few indicated experience of 'no problems' or a 'single problem'.

As can be seen from the table below, the most commonly reported area of concern is documentation related to medical and nursing treatment received by residents in the hospitals prior to transfer back to the aged care home. The issue attracting least attention from the list is that of resident nutrition status following hospitalisation however it still accounts for over one in four responses.

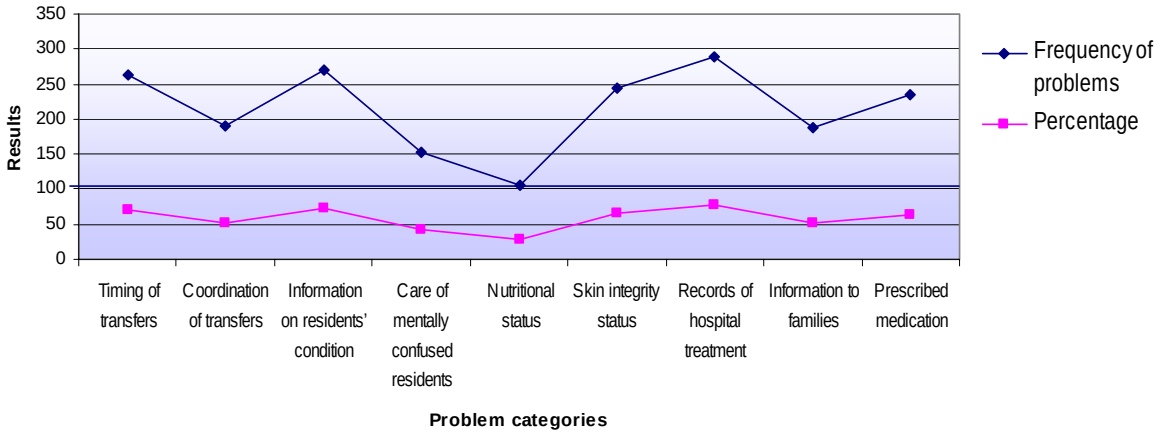
Table 7 Problem areas in resident transfers from hospitals

	Responses	%
Timing of transfers of residents from hospital to your facility	263	70.89
Coordination of transfers to allow time for preparation for resident arrival	190	51.21
Information on residents' condition prior to accepting the transfer	269	72.51
Appropriate management of mentally confused people prior to transfer to facility	153	41.24
Nutritional status of residents on arrival at your facility	105	28.30
Skin integrity status of residents on arrival at your facility	245	66.04
Documentation of medical and nursing treatment prior to transfer to your facility	290	78.17
Information provided by acute care to residents' families prior to arriving at facility	188	50.67
Medication regime prescribed prior to transfer to your facility	235	63.34

(Allows for multiple answer selection)

The graph below shows the frequency of incidents reported across Australia. Several problem areas experienced by respondents in relation to residents on their return from a hospital stay are clearly identified. Also shown are national percentages of problems within each category.

Australia-wide problems with resident transfers from hospital



Management issues relating to the timing and coordination of transfers back to aged care homes; information provided on residents' condition prior to transfer back to the aged care home; and the most commonly reported problem is the poor quality and amount of documentation received about the treatment and care the resident received during their hospital stay.

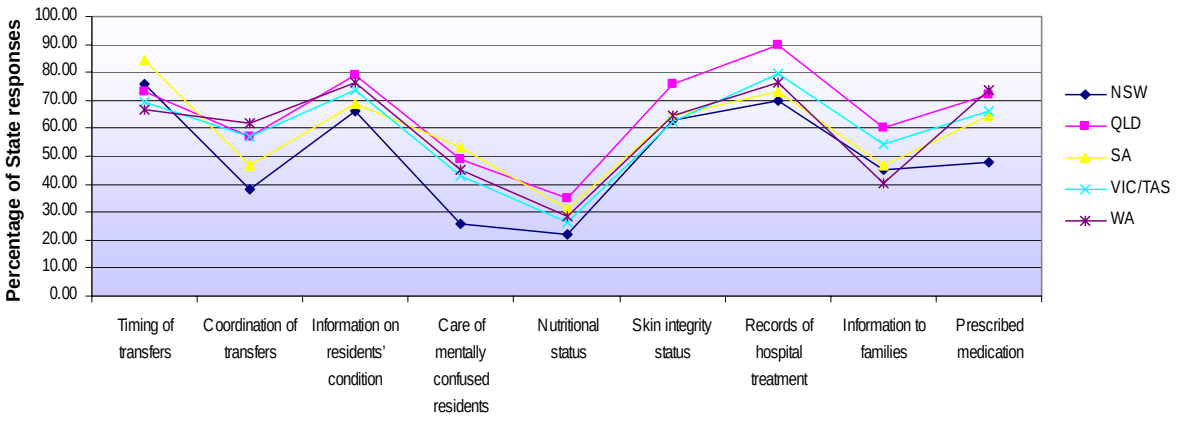
Care or clinical problems are less prominent than hospital management or organisational problems however it is of concern that these problems are present at all. In order of frequency, clinical problems were identified around the condition of residents' skin; prescribed medication; management of mental confusion; and nutritional status of residents following hospitalisation.

78.2% of respondents identify documentation of hospital treatment as a concern while almost as many respondents (72.51%) identify a paucity of accurate and relevant information about residents' condition prior to their arrival at the RACF as problematic. 70.9% of respondents report problems with timing of transfers from hospital. These major areas of concern are made even more critical when 66.04% identify problems with residents' skin integrity following hospital stays, and 63.34% identify problems for residents related to medicines prescribed while in hospital.

Problem categories vary between States however patterns of emphasis on particular problems are relatively similar. The distribution graph below shows the frequency of problems by State.

While the frequency of problems reported provides an idea of just how many people are affected by these problems, it is not until the percentage of each State response is calculated that the extent of problems being experienced locally can be fully appreciated. In the graph below NSW is clearly ahead of other States in their efforts to address problems but even so, improvement is needed across the board and especially in the categories of timing of transfers and information provided to families.

State wide percentage distribution of problems reported



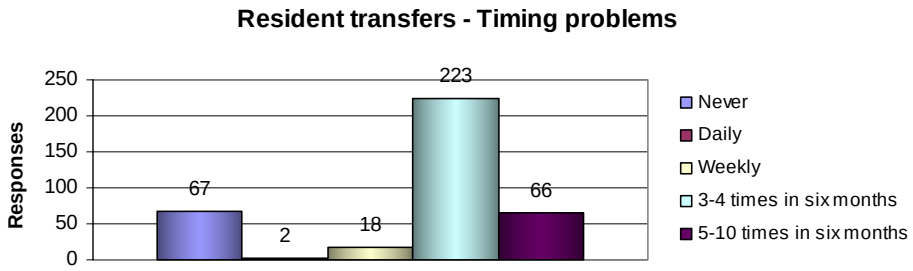
Problem categories

The array of problem areas highlighted above requires deeper examination of participant responses in order to better understand these issues.

Respondents were asked to indicate the frequency of occurrence of these problems as experienced by their organisation and also to submit clarifying comments if they wished. Each of the areas of concern is detailed in the following sections in relation to each participating State. Thematic analysis of comments submitted voluntarily by many respondents in support of their answers is used to add richness to the data and a human face to the matters discussed.

6 Timing of transfers of residents from hospital to your facility

Timing of transfers back from hospitals to aged care homes, and also receiving new admissions to aged care at appropriate times is a significant issue for the aged care industry and one about which 53% of respondents (n=197) volunteered comments. While the majority of these timing problems occur less than monthly, most of those who commented made it clear that poorly timed transfers of residents compromise their safety.



6.1 New South Wales

In New South Wales (NSW) where 100 respondents participated in the survey, it is interesting that the issue seems to occur despite the location of the aged care facility.

NSW	***Frequency of transfer timing problems***					
Location of facility		3-4 times in six months	5-10 times in six months	Weekly	Never	**Total**
A large metropolitan centre	Count	19	14	1	5	39
	% category	48.72	35.90	2.56	12.82	100.00
	% of Total	19.00	14.00	1.00	5.00	39.00
In a large regional centre	Count	14	4	0	2	20
	% category	70.00	20.00	0.00	10.00	100.00
	% of Total	14.00	4.00	0.00	2.00	20.00
In a small country town or village	Count	5	2	1	3	11
	% category	45.45	18.18	9.09	27.27	100.00
	% of Total	5.00	2.00	1.00	3.00	11.00
In the outer suburbs of a city	Count	21	3	2	4	30
	% category	70.00	10.00	6.67	13.33	100.00
	% of Total	21.00	3.00	2.00	4.00	30.00
Total	Count	59	23	4	14	100
	% category	59.00	23.00	4.00	14.00	100.00
	% of Total	59.00	23.00	4.00	14.00	100.00

In the above table only 12.82% of respondents from large metropolitan centres are able to say that they have never experienced any problems with residents arriving from hospitals without warning, or at different times than were arranged. In the outer suburbs of cities 13.33% are able to make a similar claim but

relatively speaking, regional areas have fewer respondents (10%) who have never had these problems. While the respondent numbers are lower in small towns the proportion saying they have never experienced problems with timing of transfers is 27.27%.

No doubt there are explanations for these differences and it is likely that in smaller towns where both residents and staff are known to the community, a higher level of visibility and therefore accountability could be a factor in extra care being taken. Equally, the resources for transferring residents to and from hospitals are potentially quite different from those of larger centres.

6.2 Queensland

In Queensland (QLD) respondents (n=86) provided views on whether timing of resident transfers is causing problems. Only 13% are able to say they had never had such experiences. Proportionately every location seems to be experiencing problems with timing of transfers and while the large regional centres have the largest number of respondents, they also have an issues level of 81.49% both in regional and in large metropolitan centres.

QLD	***Frequency of transfer timing problems***					
Location of facility		3-4 times in six months	5-10 times in six months	Weekly	Never	**Total**
A large metropolitan centre	Count	11	5	0	3	19
	% category	57.89	26.32	0.00	15.79	100.00
	% of Total	12.79	5.81	0.00	3.49	22.09
In a large regional centre	Count	15	7	2	3	27
	% category	55.56	25.93	7.41	11.11	100.00
	% of Total	17.44	8.14	2.33	3.49	31.40
In a small country town or village	Count	13	2	0	4	19
	% category	68.42	10.53	0.00	21.05	100.00
	% of Total	15.12	2.33	0.00	4.65	22.09
In the outer suburbs of a city	Count	14	3	1	3	21
	% category	66.67	14.29	4.76	14.29	100.00
	% of Total	16.28	3.49	1.16	3.49	24.42
Total	Count	53	17	3	13	86
	% category	61.63	19.77	3.49	15.12	100.00
	% of Total	61.63	19.77	3.49	15.12	100.00

Because all locations have around 80% level of problems with timing it is difficult to speculate on what may be causing such widespread difficulty with timing of transfers. Further investigation is needed into the systematic elements affecting resident transfers such as ambulance transport systems; medical time management in relation to discharges; and hospital discharge policies and whether RACF patients are prioritised differently to community-based patients.

6.3 South Australia

The South Australia (SA) respondent experience of problems in timing of resident transfers (shown in the table below) was provided by 45 people who hail from each of the facility location categories. Even so 22.22% of them are able to say that they have never experienced problems in this activity.

SA		*Frequency of transfer timing problems*				
Location of facility		3-4 times in six months	5-10 times in six months	Daily	Never	**Total**
A large metropolitan centre	Count	14	1	0	4	19
	% category	73.68	5.26	0.00	21.05	100.00
	% of Total	31.11	2.22	0.00	8.89	42.22
In a large regional centre	Count	5	1	0	2	8
	% category	62.50	12.50	0.00	25.00	100.00
	% of Total	11.11	2.22	0.00	4.44	17.78
In a small country town or village	Count	4	0	0	4	8
	% category	50.00	0.00	0.00	50.00	100.00
	% of Total	8.89	0.00	0.00	8.89	17.78
In the outer suburbs of a city	Count	8	1	1	0	10
	% category	80.00	10.00	10.00	0.00	100.00
	% of Total	17.78	2.22	2.22	0.00	22.22
Total	Count	31	3	1	10	45
	% category	68.89	6.67	2.22	22.22	100.00
	% of Total	68.89	6.67	2.22	22.22	100.00

Large regional centres in South Australia have the lowest proportion of respondents saying there are no problems while 88.9% of the respondents experience problems almost every week. Proportionately, most of the problems with timing of transfers occur in metropolitan (78.94%) and outer suburban centres (100%).

Country towns and villages appear to have the least problems with 50% claiming never to have had problems with transfer timing.

6.4 Victoria and Tasmania

Victoria (VIC) and Tasmania (TAS) respondents ((n=98) combined pattern of responses to this issue show that the problems relate more to regional and country area experiences than to cities and suburbs. 91.67% of regional respondents have experienced problems from time to time in this activity whereas 52% of respondents from country towns claim that these problems are frequently experienced and even daily in one case.

With 25 respondents from small country towns claiming that almost every second transfer involves problems with timing, it is interesting to think about what could be occurring in these small centres and whether some strategies might be possible to improve the situation. From the qualitative data provided, effective communication between services seems to be a key factor in timing of resident transfers, however there is no way from the data received to identify particular local issues or to identify remedial strategies being attempted.

VIC/TAS		*Frequency of transfer timing problems*					
Location of facility		3-4 times in six months	5-10 times in six months	Weekly	Daily	Never	**Total**
A large metropolitan centre	Count	20	7	5	0	3	35
	% category	57.14	20.00	14.29	0.00	8.57	100.00
	% of Total	20.41	7.14	5.10	0.00	3.06	35.71
In a large regional centre	Count	9	2	0	0	1	12
	% category	75.00	16.67	0.00	0.00	8.33	100.00
	% of Total	9.18	2.04	0.00	0.00	1.02	12.24
In a small country town or village	Count	9	2	1	1	12	25
	% category	36.00	8.00	4.00	4.00	48.00	100.00
	% of Total	9.18	2.04	1.02	1.02	12.24	25.51
In the outer suburbs of a city	Count	15	4	2	0	5	26
	% category	57.69	15.38	7.69	0.00	19.23	100.00
	% of Total	15.31	4.08	2.04	0.00	5.10	26.53
Total	Count	53	15	8	1	21	98
	% category	54.08	15.31	8.16	1.02	21.43	100.00
	% of Total	54.08	15.31	8.16	1.02	21.43	100.00

6.5 Western Australia

Western Australia (WA) respondents (n=42) are drawn mostly from large metropolitan areas and outer suburbs. The pattern of responses for these areas shown in the table below indicates a greater satisfaction with timing of transfers within metropolitan centres than with regional or country areas.

They appear less satisfied with the timing of transfers in the outer suburbs of cities with only 9.09% able to say they have never experienced problems in this activity.

WA		*Frequency of transfer timing problems*				
Location of facility		3-4 times in six months	5-10 times in six months	Weekly	Never	**Total**
A large metropolitan centre	Count	10	5	0	6	21
	% category	47.62	23.81	0.00	28.57	100.00
	% of Total	23.81	11.90	0.00	14.29	50.00
In a large regional centre	Count	7	0	1	1	9
	% category	77.78	0.00	11.11	11.11	100.00
	% of Total	16.67	0.00	2.38	2.38	21.43
In a small country town or village	Count	0	0	0	1	1
	% category	0.00	0.00	0.00	100.00	100.00
	% of Total	0.00	0.00	0.00	2.38	2.38

In the outer suburbs of a city	Count	8	1	1	1	11
	% category	72.73	9.09	9.09	9.09	100.00
	% of Total	19.05	2.38	2.38	2.38	26.19
Total	Count	25	6	2	9	42
	% category	59.52	14.29	4.76	21.43	100.00
	% of Total	59.52	14.29	4.76	21.43	100.00

6.6 Qualitative themes

Comments received are frequently critical of ambulance services and the way the ambulance service is organised in relation to providing transport for older people as well as safety issues arising from a perceived lack of due care. Respondents report problems arising from ambulance resourcing and workload management strategies; lack of consideration for the constraints under which aged care staff work; and a lack of kindness or consideration for elderly residents and their comfort and the needs of family members.

A selection of comments by respondents provides a rich coverage of their experiences with timing of resident transfers:

6.6.1 Problems with ambulance and transport services

Respondents demonstrate a deep understanding of difficulties associated with reliance on ambulance services to provide transport to discharged residents. The following comments indicate an understanding that resident transport is not given priority:

> *We are reliant on ambulance transfers for many of our new admissions. The ambulance service in this area is not divided into transport and casualty so we wait for case calls to finish as they are prioritised before resident transport.*
>
> *Frequently transport is booked for 10am but resident arrives at facility at 5-6pm.*

Also there is clear understanding that transport services seem not to have effective systems of communication or coordination:

> *As the timing is often dependent on ambulance services these services should have stronger links and communication with all parties.*

The most concerning observations about ambulance services and transport relate primarily to the lack of consideration given by hospital and ambulance staff to the safety and comfort of residents, but also the lack of due care in ensuring that staff resuming care of residents are notified and informed:

> *We do not have any problems with accepting a resident at any time, the problem has been on one occasion the transport personnel allowed a resident with early dementia to walk up the drive way and into the building on return with no escort or hand over. Resident given medications in a bag and an envelope containing discharge letter and told to go inside. The transport personnel left, without even waiting for the resident to go inside the building. When I queried this incident with ----- Hospital I was informed that they are very busy. Luckily our staff member observed this through a window and went and got the resident. This potentially may have caused harm if the resident had wandered off out onto the street, became lost etc.*

6.6.2 Inappropriate arrival times back at the aged care facility

There seems to be a widespread practice by hospitals to delay transfers of residents to aged care homes until quite late in the evening. Most hospitals have a policy indicating that older people should not be discharged after 9 pm however this practice does not take into account the transport issues which could involve a three hour trip to multiple destinations following discharge. From responses received it is fair to say that the disruption and risks associated with residents arriving home unannounced or following long periods of travel, seem ill-considered by hospital staff as they make their decisions about discharge:

> *1. Residents transferred late afternoon or weekends when we have no access to the resident's pharmacy to amend medication packs and after the Registered Nurse has left the facility for the day. 2. Residents who have been transferred to A&E for assessment of an acute medical episode being returned to the facility in the middle of the night i.e. at 0220hrs or 0300hrs. 3. Little or no warning of residents' transfer.*
>
> *Not told of transfers until resident has left the hospital. Trying to discharge late in the pm, and often on a Friday afternoon. Told that a resident will be discharged after he/she has seen 2 or 3 health care professionals and then they will be ready for discharge - time delay making their arrival very late. Resident has been discharged from the hospital wards as late as 9 pm at night.*
>
> *Very late afternoon / early evenings for resident transfers. This is not appropriate for Aged Care. We explain to the hospital that there are only certain times of the day that we can transfer back. This is ignored to the extent that they will transfer up to 10pm. we have also provided specific days and times to enable us to have the appropriate staff available. This has also been ignored. We recently received a new resident a day early. Room wasn't ready.*
>
> *Return is often at night and is not good for the resident especially if the resident has dementia and in isolated areas it is very difficult for their families to be at the home if they wish to meet them.*

6.6.3 Perceptions of care and safety compromised by timing of resident return to facility

Concerns expressed by respondents extend well beyond the inconvenience experienced by aged care managers as they compensate for late and often unannounced arrivals of residents back from hospital. Comments shown below typify the genuine concern of aged care staff for the safety of residents who have been through an unsettling and often disorganised process resulting in their arriving back at the aged care home without essential medications or information that would enable staff, including doctors, to provide safe and effective care and treatment.

> *Residents arrive whose condition is not as stated without discharge summary, medications not sorted, doctor sometimes not advised*
>
> *If residents arrive late in the afternoon, they are often confused, uncooperative, and anxious and it can be very difficult to get the doctor organised late in the evening*
>
> *In the recent past I have refused to accept residents who are being returned after 5pm, as this is unfair and detrimental to their health state particularly when a resident with C.A.L. arrives at 3am on a winter's morning.*

In some instances, residents with dangerous conditions are transferred without due process or concern for their safety or the safety of other aged care residents or staff at the RACF.

> *We have had one client transferred inappropriately, without full confirmation that we could even take her. The client was returned to hosp.*

> *ACAT was totally insufficient information. Client had active resistant multi strain infection and we were unable to isolate her effectively so could not admit her.*

Even basic advice as to follow-up medical and nursing care needed by residents seems to be missing in many instances. The comment below is typical of many received through this survey:

> *Transfer of residents without notice to the facility, arriving later than advised, and late in the day making arrangements for medications and medical review difficult, particularly on a Friday or weekend. It is not possible to supply medications to a resident without a current medical chart and time to order medications from pharmacy, posing significant risks and severe pain when regular doses delayed. Advice regarding care needs of resident inaccurate, even high care or low care status is not accurately assessed making relocation of resident to appropriate care level (Nursing Home & Hostel on site with separate provider numbers) a funding and care priority but difficult process to achieve. Poor resident prognosis and complex care needs not advised to facility, and resident death (in as short as 12 hours after arrival) makes care provision difficult, especially if family are not aware either.*

And then there are stories that, if true, demonstrate appalling callousness towards patients that everyone associated with the health and helping professions should find unacceptable:

> *Residents discharged overnight (i.e. 2am) returning to Hostel via taxi with no prior notification.*
>
> *One elderly gentleman returned following investigations of chest pain, without his shirt, no money, no key, in a taxi at around 3am. He woke the neighbours who contacted off-duty staff who came and let him into his hostel.*

6.6.4 Perceptions of a lack of due consideration by hospital staff for aged care industry limitations

With so many aged care homes experiencing problems with the way hospital staff transfer residents following hospital stays, it is not surprising that a perception has grown that hospital staff are at best unaware of the resource limitations under which aged care facilities operate and therefore their expectation of hospital services to be available in aged care; and at worst their attitude is seen as one of indifference to the suffering and risks that may arise from their misunderstanding of services available within residential aged care.

> *Acute system not aware of nursing home pressures and staffing levels, therefore unrealistically expect nursing home to have full complement of staff for most of the day.*
>
> *Acute hospitals often have no idea of resource requirements in the home and as such try to get residents back as quickly as possible and this lacks a planned consistent approach*

Risks associated with hospital staff not understanding aged care limitations, directly impact residents who may require care and treatment that has not been communicated to aged care staff, and thereby compromising resident access to effective care. Some comments indicate attempts to return patients to hospitals when discharge has been inappropriate:

> *Resident returned in palliative care state, who was originally in a secure dementia unit. We refused to admit her back and explained that we had no high care bed available and that she is unsafe in dementia unit. Resident was transferred anyway back to us.*

But mostly comments relate to inconsiderate practices of hospital staff whose focus seems to be on discharge rather than any professional interest in continuity of care and safe transfer of their patients to another service:

> *Hospital insists on resident's return then does not arrive; Sends residents without consultation; Sends resident, drops them off by cab and resident is unable to enter locked facility; Takes residents word without checking with facility; Inappropriate type of transport; Sends resident in the middle of the night without notice and no staff on site.*
>
> *Residents have been sent home on week-ends despite the fact that RN's only available 'on call for emergencies' phone calls saying a resident may be coming home in a few days and then getting a call saying the resident is already in an ambulance on the way back to facility.*
>
> *Residents arrive on weekend no notice, no medications packed in Webster packs, and no transfer information e.g. resident went to local hospital with? Flu like symptoms, returned on a Saturday following insertion of a pacemaker. Limited staffing i.e. only care service employees on made this a difficult situation. Often residents are returned late in the evening when there is limited staff - creates problems when no transfer information is provided and medication changes have taken place with no follow up on what is required.*

6.6.5 Perceived lack of courtesy for older people and their needs

In many cases, the treatment of older people who have been in hospital was perceived by respondents as simply being rude or lacking in civility or common courtesy towards others. All medical and nursing staff in hospitals will have had exposure during their training to the idea that residential aged care provides a home for people who need extra social support and access to some personal care services. As such, aged care provides people with a home where they live with others in a communal setting which depends for success on the fact that everyone is considerate of each others' needs. As a resident's level of health care need increases efforts are made by aged care nurses and their staff to access medical care and treatment that they cannot provide, just as anyone living in their homes would even with the assistance of community nurses.

There is no surprise then that respondents express disappointment with their acute care colleagues whose behaviour towards residents, families and themselves, is interpreted as rude and discourteous:

> *We have had three instances of residents being transferred back in the early hours of the morning e.g. 0300 hrs. A new resident was transferred at 2145 (last week) other instances of transfers during the evening.*
>
> *Residents being transferred back to the facility after 2300 hours and at times 0300 -0500 in the am. This causing distress to residents their families and the staff at the facility*
>
> *In the last week a Resident was discharged to another facility without consultation. Residents arriving in taxis or ambulance without notification. Resident discharged and arrived back at this facility at 2.40am other residents discharged without notification after-hours.*

In some instances, hospital staff transfer people back to the family home despite knowing that they were admitted from a residential aged care facility:

> *A number of our clients were transferred home without notification to us as the provider; a number are transferred home late at night or early hours of the morning to no family.*

Disruption and stress caused by rudeness and lack of kindness and consideration by hospital staff can leave residents quite upset and uncomfortable. Families given inaccurate or misleading information when they contact the hospital also results in anxiety that could be avoided with a small amount of care and consideration:

> *The acute facility is not able to advise within a one hour timeframe the arrival time of the resident. This often results in the resident arriving in a very agitated state, being confused and having no understanding of what is happening to them.*

> *Estimated times are given and tendency for residents to turn up whenever. Family & facility are told different times. Sometimes they turn up at meal times or other busy times during our facility which makes it hard to welcome & settle them. Sometimes they turn up after meals, without receiving a meal at the hospital.*

6.6.6 Aged care efforts to understand the limitations of acute care contexts

While the previous section is typical of the vast majority of comments received, a few aged care staff are making an effort to understand difficulties faced by hospital staff in relation to ambulances, residents and the pressure for hospital bed availability. Some could understand the pressure to discharge people to relieve bed shortages in acute hospitals:

> *Despite regular contact regarding discharge date and then time of discharge, the decision appears to be linked with need for beds.*
>
> *Acute facilities want residents out of the acute bed often before either the client or the facility is ready to accept them on transfer.*
>
> *When the pressure for beds is significant at the Acute Facility, the timing of transfers to Residential Aged Care is more difficult to influence and ensure it meets the needs of all.*

Other comments showed an understanding of systems currently in use in acute hospitals that prevent timely discharges:

> *Residents with dementia transferred back late in the afternoon. Hospitals have stopped the discharge back late into the evening. Resident's could not be discharged earlier as hospital doctors did not do rounds until after 5pm.*

6.6.7 Perceptions of fewer problems with transfers and some suggestions

Not all respondents claim to be experiencing problems with timing of resident transfers. Some comments identify benefits that can be achieved through effective communication between services:

> *Belong to an organisation which has both acute and aged care facilities. Most transfers have occurred from organisation's acute facilities so acute and nursing home staff actually talk to one another to agree on time.*
>
> *We instruct the hospital when we can accept the resident and they usually comply.*
>
> *Residents being returned late afternoon. Hospital generally very good and do not return residents late Friday but may, if really pushed, transfer on weekends. They do negotiate about the weekends*
>
> *Communication with our local hospitals has been good and timing agreeable.*
>
> *In my experience our local hospitals are very flexible and willing to wait until room is prepared.*

The relationship between hospitals and the aged care home seems to be an important element in successful negotiation of arrangements that suit both partners:

> *Timing of resident transfer is not usually a concern. I find that the transferring health service is so pleased to have found accommodation that they are very receptive to the time frame suggested to them.*
>
> *No problems with timing of resident transfer experienced at this facility*
>
> *No problems. A good working relationship with the area health service and the ACAT team.*

> *As we are attached to a hospital the timing of transfers has been good on site. Transfers from regional hospitals is not good as the discharge planner has not informed the facility of the discharge, this has happened on a number occasions. The resident then arrives out of business hours when there is no one to accept the transfer or arrange for any medication to come from the chemist as there is no registered nurse on site - only personal carers.*

6.7 Summary and recommendations

The impression gained by residents, families and aged care staff of hospital personnel involved with transfers is that they are mostly discourteous and unconcerned with the comfort or safety of older people whom they transfer away from their place of work. Comments in relation to the lack of professional respect emanating from hospitals imply a diminishing level of trust that professionals in the community and in aged care dare to hold about hospital personnel. Such views about the proficiency and diligence of hospital staff make it more difficult to meet legal and care responsibilities towards older people in this situation, and also to establish a mechanism that supports continuity of care that meets safety and quality standards.

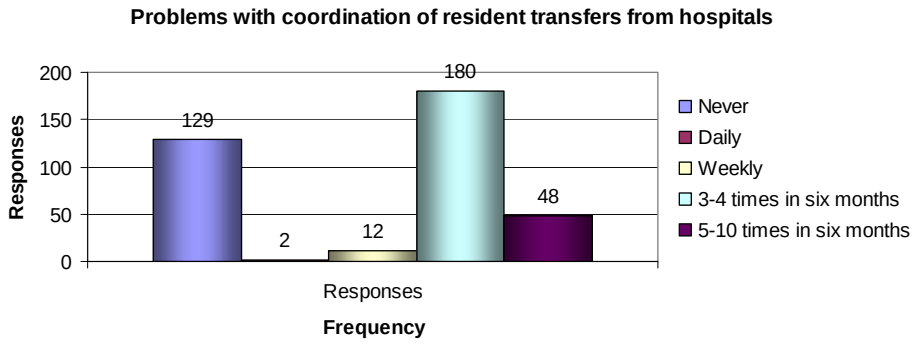
6.7.1 Recommendations

Communication. Aged care and hospital leaders need to set up systems that standardise inter-agency communications around resident transfers. As part of this system, the logistics of transfers need close scrutiny and improvement in terms of timing of discharges; timing of communication; timing of transport; and codes of conduct for all personnel involved.

Policies and protocols. An inter-agency collaborative opportunity is needed to identify the causes of long delays in ambulance services; the prioritising of residents from aged care who are in hospital; and discharge policy monitoring so that remedial action can be taken as needed.

7 Coordination of transfers to allow time for preparation for resident arrival

Overall, coordination of the transfer of residents seems less of a problem than timing issues discussed above. Most respondents appear to have tried to coordinate residents' transfers and when compared with timing issues some success has been experienced by several respondents. However, a large group of almost half of the respondents (48%) still seem to be experiencing problems in this regard.



The following tables show different State results cross tabulated with whether the facility is located in a metropolitan, outer-metropolitan, large regional centre or in a small town.

In New South Wales (NSW) most instances of transfer coordination problems involve large metropolitan and outer suburban hospitals although, in these locations reports of never having experienced a problem in this regard are only slightly less than problems reported. In the regional and country areas the reverse is true. Even though smaller numbers of occurrences are reported in these locations, it is clear from the table that problems are more commonly experienced than not.

7.1 New South Wales

NSW		***Frequency of transfer coordination problems***					
Location of facility		3-4 times in six months	5-10 times in six months	Weekly	Daily	Never	**Total**
A large metropolitan centre	Count	15	4	1	1	18	39
	% category	38.46	10.26	2.56	2.56	46.15	100.00
	% of Total	15.00	4.00	1.00	1.00	18.00	39.00
In a large regional centre	Count	11	4	0	0	5	20
	% category	55.00	20.00	0.00	0.00	25.00	100.00
	% of Total	11.00	4.00	0.00	0.00	5.00	20.00
In a small country town or village	Count	6	2	0	0	3	11
	% category	54.55	18.18	0.00	0.00	27.27	100.00
	% of Total	6.00	2.00	0.00	0.00	3.00	11.00

In the outer suburbs of a city	Count	10	3	2	0	15	30
	% category	33.33	10.00	6.67	0.00	50.00	100.00
	% of Total	10.00	3.00	2.00	0.00	15.00	30.00
Total	Count	42	13	3	1	41	100
	% category	42.00	13.00	3.00	1.00	41.00	100.00
	% of Total	42.00	13.00	3.00	1.00	41.00	100.00

7.2 Queensland

In Queensland (QLD) it appears that the only location where more reports occur of never experiencing transfer coordination problems than there are problems is in the small towns or villages, but the difference is very small.

Large metropolitan, large regional and outer suburban areas have significantly more problems reported by respondents (53) than those who say they never have such experiences with coordination of resident transfers (14).

QLD	***Frequency of transfer coordination problems***					
Location of facility		3-4 times in six months	5-10 times in six months	Weekly	Never	**Total**
A large metropolitan centre	Count	11	3	0	5	19
	% category	57.89	15.79	0.00	26.32	100
	% of Total	12.79	3.49	0.00	5.81	22.09
In a large regional centre	Count	15	7	0	5	27
	% category	55.56	25.93	0.00	18.52	100.00
	% of Total	17.44	8.14	0.00	5.81	31.40
In a small country town or village	Count	8	1	0	10	19
	% category	42.11	5.26	0.00	52.63	100.00
	% of Total	9.30	1.16	0.00	11.63	22.09
In the outer suburbs of a city	Count	13	3	1	4	21
	% category	61.90	14.29	4.76	19.05	100.00
	% of Total	15.12	3.49	1.16	4.65	24.42
Total	Count	47	14	1	24	86
	% category	54.65	16.28	1.16	27.91	100.00
	% of Total	54.65	16.28	1.16	27.91	100.00

7.3 South Australia

South Australia (SA) has a similar pattern of response distribution to Queensland. Again only country towns have more respondents claiming never to have had problems with coordination of resident transfers (62.5%) than those who claim they have problems (37.5%). While the State sample is small, it is possible to put responses in perspective using percentages and when this is applied to SA responses, respondents who experience frequent difficulties with coordination of transfers are highly represented from large regional centres (75%).

SA		*Frequency of transfer coordination problems*			
Location of facility		3-4 times in six months	5-10 times in six months	Never	**Total**
A large metropolitan centre	Count	9	3	7	19
	% category	47.37	15.79	36.84	100.00
	% of Total	20.00	6.67	15.56	42.22
In a large regional centre	Count	6	0	2	8
	% category	75.00	0.00	25.00	100.00
	% of Total	13.33	0.00	4.44	17.78
In a small country town or village	Count	3	0	5	8
	% category	37.50	0.00	62.50	100.00
	% of Total	6.67	0.00	11.11	17.78
In the outer suburbs of a city	Count	4	2	4	10
	% category	40.00	20.00	40.00	100.00
	% of Total	8.89	4.44	8.89	22.22
Total	Count	22	5	18	45
	% category	48.89	11.11	40.00	100.00
	% of Total	48.89	11.11	40.00	100.00

7.4 Victoria and Tasmania

Victoria (VIC) and Tasmania (TAS) results shown in the table below are more relevant to Victoria than Tasmania. Still. Once again it is in small country towns that more respondents are able to claim less experience of problems with coordination of transfers than actual problems. Relatively speaking responses from facilities in large regional centres indicate they are 92% more likely to have frequent problems with coordination than successes. Respondent facilities in large metropolitan centres and the outer suburbs of cities also report significantly more problems than no problems.

VIC/TAS		*Frequency of transfer coordination problems*					
Location of facility		3-4 times in six months	5-10 times in six months	Weekly	Daily	Never	**Total**
A large metropolitan centre	Count	19	4	3	0	9	35
	% category	54.29	11.43	8.57	0.00	25.71	100
	% of Total	19.39	4.08	3.06	0.00	9.18	35.71
In a large regional centre	Count	10	0	1	0	1	12
	% category	83.33	0.00	8.33	0.00	8.33	100.00
	% of Total	10.20	0.00	1.02	0.00	1.02	12.24
In a small country town or village	Count	8	1	1	1	14	25
	% category	32.00	4.00	4.00	4.00	56.00	100.00
	% of Total	8.16	1.02	1.02	1.02	14.29	25.51

In the outer suburbs of a city	Count	10	5	2	0	9	26
	% category	38.46	19.23	7.69	0.00	34.62	100.00
	% of Total	10.20	5.10	2.04	0.00	9.18	26.53
Total	Count	47	10	7	1	33	98
	% category	47.96	10.20	7.14	1.02	33.67	100.00
	% of Total	47.96	10.20	7.14	1.02	33.67	100.00

7.5 Western Australia

Overall Western Australia (WA) seems also to have problems with resident transfer coordination, especially in large metropolitan areas. Responses from Western Australia are low however the distributional pattern of whether they experience problems or not is interesting. The table below shows that most issues arise every six weeks or so, but in metropolitan centres it can occur more often.

WA	***Frequency of transfer coordination problems***					
Location of facility		3-4 times in six months	5-10 times in six months	Weekly	Never	**Total**
A large metropolitan centre	Count	10	4	1	6	21
	% category	47.62	19.05	4.76	28.57	100
	% of Total	23.81	9.52	2.38	14.29	50.00
In a large regional centre	Count	6	1	0	2	9
	% category	66.67	11.11	0.00	22.22	100.00
	% of Total	14.29	2.38	0.00	4.76	21.43
In a small country town or village	Count	0	0	0	1	1
	% category	0.00	0.00	0.00	100.00	100.00
	% of Total	0.00	0.00	0.00	2.38	2.38
In the outer suburbs of a city	Count	6	1	0	4	11
	% category	54.55	9.09	0.00	36.36	100.00
	% of Total	14.29	2.38	0.00	9.52	26.19
Total	Count	22	6	1	13	42
	% category	52.38	14.29	2.38	30.95	100.00
	% of Total	52.38	14.29	2.38	30.95	100.00

7.6 Qualitative themes

157 respondents volunteered comments on coordination of transfers and of these comments 12.74% (n=20) report not having any problems in coordinating resident transfers with the hospital. For the other 87.26% (n=242) who did report problems, the selection of comments shown below provides insight into the types of coordination problems and some of the views shared by respondents:

7.6.1 Coordination is not considered to be a problem

Successful coordination of transfers between hospitals and aged care homes was reported by a small number of respondents. In some instances, families also assist with transfer coordination efforts:

> *Most of the time they have been smooth as I intercept and remind the discharging hospital of the paperwork required by the facility before discharge and return to the hostel. Often the issue is around medication, prescriptions or further appointments.*
>
> *Family usually drive residents from city and we work with family for the co ordination of transfer.*
>
> *We have a very good QAS relationship and they are usually fairly flexible and fit in with us when they can.*

7.6.2 Coordination is a problem related to ambulance services

Despite every best effort to coordinate transfers, there is again evidence of difficulty related to ambulance services. Where possible, aged care staff try to involve families in transporting their relatives back to the home but this is not always possible. Comments typical of many referring to ambulance services are shown below:

> *The only issues relate to waiting time for ambulance transfers .*
>
> *Unable to get Ambulance when we need it to transfer.*
>
> *The main problem is with ambulance transfers as they cannot give you an ETA.*
>
> *Arrival time is out of our control due to reliance on ambulance transfers. Family/friends unable to assist with transfer for the resident.*
>
> *Delays due to unavailability of transport. Families not always able to transfer in private vehicle. No family living in the state.*

A problem also seems to exist in terms of ambulance officer communication with aged care staff in relation to resident transfers and coordination of services:

> *Ambulance officer can be quite terse to the staff. They do not accept the information from our RN's e.g. Blood pressure, blood sugar levels or head injury observation.*
>
> *On many occasions we are not informed of their pending arrival and the resident just turns up in the ambulance. At other times staff will phone in the morning, but are unable to provide an accurate time.*
>
> *Similar - we are told that the client must await patient transport no time is ever given and often the resident is arriving at the same time we are receiving the call to advise us that they are being discharged.*

And while the inconvenience of uncoordinated transfers is obvious, aged care staff are more concerned about the discomfort and stress endured by residents who arrive late at night; who travel for hours in the back of a van; who miss meals and have nothing to drink; and who have little or no access to toilet facilities:

> *Most often residents arrive back much later than stated and miss out on meals.*
>
> *Transport as was arranged - not 8-9pm at night after staff waiting since early am... and residents not given food or drink.*

7.6.3 Communication as a cause of poor coordination of transfers

Communication between services coordinating resident returns from hospital stays prompted a very large number of respondents to voice concern. For some respondents there seems to be no coordination effort evident at all:

There is no coordination they simply arrive.

Sometimes resident arrives and there's been no communication.

Resident "just arrives" back at facility.

Sometimes no advice given - resident arrives unannounced.

Either no consultation and resident arrives without warning or resident in transit when hospital advises of transfer.

Residents have arrived back with no warning on several occasions, one with a catheter, one requiring complex pain management.

Sometimes they arrive without warning or are already in transit.

Arriving without notice.

Short notice.

No prior phone calls received. Resident just arrives.

Where some coordination effort is apparent, respondents commented on the inadequacy of communication received:

Hospital sends resident without pharmacy orders. No discharge information. Rarely receive discharge plan. Send resident without notice. Sends resident at odd times and leaves them at the door unable to enter. Rudeness in insisting they must come back today then end up not returning at all. Disinterest in information about the residents at times.

Often a transfer has been organised, then the Hospital rings to say that they haven't completed their tests; results or resident is now too unwell to transfer on that day. Then they want to transfer on a weekend.

Hospital indicates the resident is medically stable but on arrival to facility the resident's condition remains the same. Also what Hospital agrees to send with the resident doesn't arrive.

No information on health status or ongoing management; often return with no written documentation.

Inconsistencies in information received about resident transfers is also a cause for concern by aged care homes whose staff need to set up services to support the returning resident:

Resident arrival at facility delayed and no advice from hospital e.g., arrival anticipated at 10am resident arrived at 7pm.

Very short notice by phone (10-20min). Agreed a time which was then changed to much earlier at very short notice.

Mixed messages from hospital, family and GP/specialist.

Often informed resident will be home "just after lunch" they turn up after evening meal has finished.

We are often told admission will be on a certain day, only to have that decision changed on the day of admission.

Attempts to overcome communication problems were also commented upon but again, most respondents provided comment about difficulties encountered in retrieving reliable information from hospitals:

Nurses may tell you over the phone but no information is sent with the residents.

Difficulty contacting person in acute facility who knows of transfer details.

Difficulty communicating direct with ward or ED department.

Very difficult to coordinate as communication breaks down between shifts and not all staff are aware of transfer details.

Lack of communication re condition of resident, whether have had meal, or need any special care or equipment not readily available.

Receive umpteen phone calls from different staff re same resident.

Communication between hospital staff and residents' families was also commented upon in relation to helping families to know what was happening or to assist with the transfer of their relatives back to the aged care home:

> *Often the whole process takes place on the same day. We are notified of the need for a bed, we confirm availability and the new resident usually arrives the same day. This puts pressure on the hospital where the resident is transferring from, our admissions doctor and our organisation. It can also be an overwhelming experience for the resident and family.*
>
> *Families not always aware.*
>
> *The hospital does not contact facility to say that resident is coming home.*
>
> *Lack of information, elders circumstances and families obligations not taken into account.*

The most common category of comments was in relation to the lack of notice causing extra work and rushing to prepare for residents' safe return to aged care:

> *Occasionally we will be notified that the new resident is being discharged from the hospital when they actually left the hospital headed for the nursing home, not the morning of or even better the day before to allow time to ensure the room/ bed space is prepared adequately.*
>
> *We like to use services that protect our resident and often that takes hospital a while to agree to and organise.*
>
> *Lack of communication in allowing smooth transfer of patients to the nursing home.*
>
> *Short notification or resident did not arrive on time making it hard for GP to visit. As result of this, locum used on few occasions to attend to medication charts.*

7.6.4 Resident safety related to resident transfer coordination problems

The issue of resident safety compromised by poor coordination of transfers from hospitals was raised by a large group of respondents. These concerns relate to significant risks arising from lack of proper handover of clinical treatment needed and details of essential care not well communicated or coordinated by the discharging hospital:

> *Residents returned to facility without prior notice that he was now insulin dependent diabetic. Low care facility with no registered staff after 1700hrs. Staffing arrangements needed to be made, rosters changed.*
>
> *There is always an argument over returning residents post fracture back to the home without rehab. Standard answer is they will transfer without rehab because they are going back to a nursing home. Explaining you may have 6 hours physio per week is irrelevant. You have to challenge, argue and advocate against ageist attitudes and then fight more for rehab to come to the RACF if they still insist on sending them back without rehab!*
>
> *Lack of communication between hospital medical officers and the residents' GPs who are expected to take over care including writing up medication ordered in hospital. Poor discharge planning, despite the hospital having a discharge coordinator.*

Some insight into the constraints under which hospital staff work were apparent from a few respondents, however their frustration at the lack of interest or understanding by hospital staff of constraints facing aged care homes was also apparent from their comments:

> *Hospitals requesting low care residents to be transferred back to the hostel, which is staffed by Personal Care workers and the care needs of the resident exceed the knowledge base of the Personal Carers.*
>
> *The hospital often pushes to get the transfer done earlier as they have an acute bed shortage and have no idea of what is involved for the aged care facility in preparing for the transfer.*

> *Residents too unwell to return to a low care setting which has no nursing staff.*

7.6.5 Management and coordination systems related to resident transfers

Respondents' comments include views about management systems in place that could achieve safe and effective coordination of factors required for successful resident transfers to occur. Some comments relate to the timing and communication issues raised above, but other comments provide an assessment of hospital policies and procedures in place to deal with resident transfers and discharges. For instance, sometimes too many people are involved in discharge decisions; and problems with Friday and weekend discharges are compounded by uncoordinated ambulance services and a lack of information about necessary treatment:

> *There are too many health professionals involved in this decision. Add to this the expectations of one or other family members and it comes down to communication and coordination between the key players in the acute facility.*
>
> *Hospitals frequently want to transfer patients on Friday afternoon. This can create major problems with regard to getting doctors to write up changes, obtaining altered Pharmacy orders or if the resident is new getting their medical supervision organized.*
>
> *Hospital unable to give a time due to waiting for ambulance Difficulty with coordinating a residents follow up appointment, with a visit to A&E at the same hospital, the appointment was not fulfilled as the hospital said it was too difficult. We then had to reschedule, thus the frail resident had to make another trip there.*
>
> *There have been a couple of occasions when we have not been alerted or notified of the resident's impending return prior to their arrival. Also situations when we have not been advised that a resident has been discharged from the hospital to another facility i.e. nursing home.*
>
> *Acute facility wish to send residents back on a weekend and this is not appropriate in a stand alone hostel.*
>
> *There appears to be an urgency to transfer residents back to us prior to the weekend regardless of their condition - no discharge summary.*

Lack of coordination seems to be caused by hospitals having no standard protocol or process in place to notify those who need to know about the discharge, or to manage safe resident transfer to aged care homes taking over their care and treatment:

> *Often the transferring hospital does not ring relatives of transfer. Often residents are transferred back at inappropriate times e.g. after 4pm. Staffing in nursing homes is at a minimum after 3pm. Often weekend transfers are not coordinated with the receiving facility.*
>
> *Drop-off of residents not at time initially advised. Lack of ambulance officers for pick-up of residents. Inadequate or inaccurate records from hospital.*
>
> *Residents returning late in the day without medications and community pharmacy closed. Staff travel to neighbouring town in off duty time to get medications.*
>
> *Medications often cannot be administered because the pharmacy has not been informed in time to provide prepacked meds.*
>
> *It is not uncommon to have a resident arrive at our facility 5 mins after being notified by the Hospital, or have residents arrive that we were not even expecting.*

Efforts are being made in some hospitals to improve the situation and one respondent reported being included in a project that is trying to be systematic about safe discharges:

> *I have been on a committee to improve transfers from and to RACFs from -------- hospital. We have achieved significant improvement through this process and I commend the commitment of the hospital staff in putting in place a very workable system to improve discharge process. This review has looked at transfer of information, medications, pre-writing of medication sheets by registrars so drugs can continue to be safely administered until GP can review improved coordination of discharge through placement officer and development of discharge envelope which prompts all aspects of discharge for hospital staff.*

7.6.6 Coordination of resident continuity of treatment

Professional standards include taking due care to ensure that continuity of care and treatment occurs despite moving between services and different health personnel. Coordinated processes are necessary for those who need to know about the discharge and they need to be notified to ensure that essential medications and treatments can be continued during and following resident transfer to the aged care home.

Some respondents commented on the lack of, or accuracy of, information while others expressed concern about the dubious veracity of some information received from hospitals about the residents' condition:

> *No notification of discharge. No discharge letters. No coordination about discharge medication- told there are no changes and there are often multiple changes. Not told the truth about resident's condition prior to discharge, difficult in the low care setting.*
>
> *Hospital staff lack the insight into what is provided for the care of high care residents in NH and what may not be able to be provided in the Hostel if residents have not fully recovered from an acute illness.*
>
> *Medications change arrangements are the main concern. Although we have had residents discharged with cannula still in situ, and pain management patches in situ and when the hospital was contacted the particular patch had been ceased two weeks prior.*
>
> *They are often poorly coordinated rarely are we aware except 30 mins to an hour prior that a client is coming back. Rarely is consultation provided regarding specialist nursing care the client may require.*
>
> *Especially diet and skin care and allied health hand over is problematic. Nursing and medical are good at discharge, but there is little or no opportunity for regular update.*

Problems of inaccurate information on treatment are compounded by the difficulty associated with residents arriving at the home without essential supplies of medicines when it is too late in the day for arrangements to be made to obtain supplies from the local pharmacy:

> *Hospital did not send 3 day supply of medication until GP comes to rechart new meds. It is preferably if hospital chemist can communicate to our pharmacy especially for Low Care residents as they are in multi-dose packs. Sending residents on a Friday afternoon where access to GP is difficult.*
>
> *Resident discharged after medication changes, without prior arrangement, necessitating their return to hospital. Residents then arriving back at the facility in taxis and ambulances without prior notification.*
>
> *As stated previously issues with medications, time of arrival where staff expect transfer in a given time frame and Resident arrives much later without the necessary documentation.*

Aged care providers need warning of a resident's return so that appropriate care and services such as pharmacy can be arranged prior to the arrival or transferred residents:

Transfers back are often not a priority for residents and communication can be nonexistent from larger hospital.

Public hospital ringing and saying resident is already in ambulance and on way back when previously told would be 1-3 days.

Again just the sense of emergency due to need means every party feels a little stressed initially. We often don't have the key staff available on the days the transfer is to happen as we are smaller than some providers.

Residents returned with no warning and no proper discharge forms. Residents often returned very late on a Friday afternoon (after 5pm).

If we are given notice that the resident is returning then we usually have no issues with coordination.

7.6.7 Resources and costs issues related to coordination of transfers

Perhaps because such a large number of respondents are senior managers or involved in clinical governance, the issues of costs and responsibility for arrangement of services, supplies and payment for these aspects were raised.

In general the transfers are rushed and the treating Medical Officer (on discharge) does not complete their paperwork adequately of special note Medication Orders and the delay in arrival to the Facility leaves no room for GPs to attend and write up required meds or pharmacy to supply. N.B. Acute Care Facilities do not supply medication coverage on discharge nor do they provide prescriptions that can be actioned by a commercial pharmacy. Antibiotics, S8 and S4Ds are of particular relevance as Residential Care Facilities do not have stock medications.

Transfer often difficult to arrange and to define who will pay.

No time to organise equipment e.g. Shower chair, raised toilet seats, bed frames, chair raisers, walking frames etc... Resident's room may need to be re-arranged, medications may have changed significantly, may only be minimal staff available if after hours. GP not available to review.

Some residents have arrived hours later than scheduled some residents with staff escorts have been held up by the transfer lounge at the hospital requiring overtime payment to the staff escort of up to five hours We are reluctant to send staff escorts as a result of this.

Transfers occur at time other than that stated by transferring hospital. Arrive without medications and no prior notification that medications will follow from hospital pharmacy Residents being transferred back to Nursing Home by Ambulance when they do not have Ambulance cover. Transferring hospital fails to ask residents family to pick them up. Expectation is that the nursing home will provide and pay for transport and escort.

Cannot always move residents from hospital due to lack of ambulance cover.

Residents returning form hospital with no prior warning, no special facility being able to be arranged such as catheter, pumps, oxygen.

7.7 Summary and recommendations

There is no doubt that coordination issues involving all partners in the resident transfer process are generating frustration and placing residents at risk of harm. The situation is not helped by perceptions that hospital staff deliberately mislead aged care about essential work that may or may not have been completed prior to discharge just to move older people out of acute care.
Families also are perceived to be not treated well in their efforts to assist with coordination of transfers and instances of residents being sent to the family home rather than to the aged care home where they have been living, cast doubts on the skill and conscientiousness of hospital staff involved.

7.7.1 Recommendations

Formal mechanism for service coordination. A joint committee involving hospital staff, aged care and ambulance staff as well as families needs to meet in the local aged care facility to discuss ways of ensuring that safety and quality aspects of resident transfers are met. Hospitals need also to monitor discharge practices of staff and take steps to provide inservice education if there is evidence of neglectful attitudes towards older people and residents of aged care homes.

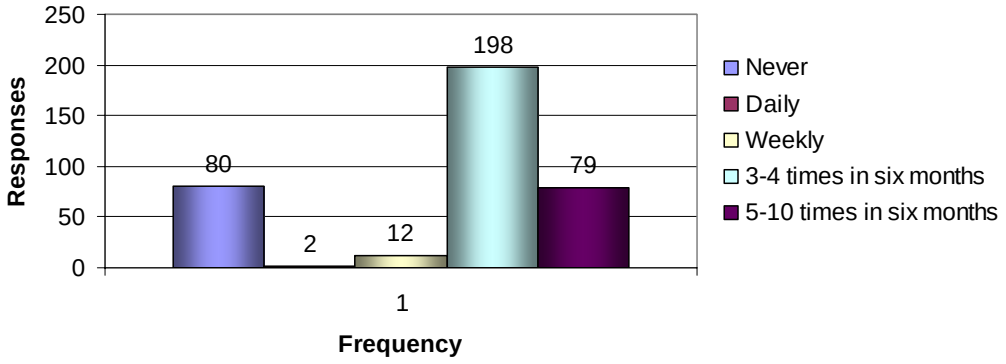
8 Information on residents' condition prior to accepting the transfer

A core issue for aged care providers is their responsibility to carefully assess prospective residents in terms of the organisation's capacity to provide appropriate care. Once a resident is admitted, mandated security of tenure applies under the Aged Care Act 1997 even if the resident's needs were not fully known or understood prior to admission.

The financial and staffing implications of accepting a resident for admission whose needs are well beyond the resources of the organisation to provide for, leaves residents with risks of having unmet needs and approved providers in a tenuous situation regarding due care and regulatory compliance.

The importance of accurate, complete and timely information on the true condition of people referred for admission and those returning from hospital following a serious injury or illness, is shown in the graph below where only 21.6% (around 1:5) respondents experience no problems at all with information received from hospitals.

Problems with reports on residents' condition prior to transfer from hospitals



On closer examination of Reponses in relation to different States and locations of respondents' facilities, a better understanding becomes possible about the extent to which location and proximity to hospitals hinders or helps access to essential information about a resident's condition prior to their transfer to aged care.

8.1 New South Wales

For NSW respondents in every location, more problems are experienced with accessing relevant and accurate information about residents than experiencing no problems at all.

In outer suburban areas and large regional centres only one in four respondents claim to have no experience of problems; in large metropolitan centres the ratio is higher with one in every 2.5 responses claiming never to have had such experiences. A similar ratio exists for small country towns in NSW.

NSW	*Frequency of information problems about resident condition*						
Location of facility		3-4 times in six months	5-10 times in six months	Weekly	Daily	Never	**Total**
A large metropolitan centre	Count	18	9	0	1	11	39
	% category	46.15	23.08	0.00	2.56	28.21	100.00
	% of Total	18.00	9.00	0.00	1.00	11.00	39.00
In a large regional centre	Count	12	3	1	0	4	20
	% category	60.00	15.00	5.00	0.00	20.00	100.00
	% of Total	12.00	3.00	1.00	0.00	4.00	20.00
In a small country town or village	Count	7	1	0	0	3	11
	% category	63.64	9.09	0.00	0.00	27.27	100.00
	% of Total	7.00	1.00	0.00	0.00	3.00	11.00
In the outer suburbs of a city	Count	18	6	0	0	6	30
	% category	60.00	20.00	0.00	0.00	20.00	100.00
	% of Total	18.00	6.00	0.00	0.00	6.00	30.00
Total	Count	55	19	1	1	24	100
	% category	55.00	19.00	1.00	1.00	24.00	100.00
	% of Total	55.00	19.00	1.00	1.00	24.00	100.00

8.2 Queensland

Queensland's responses to this question indicate that of all locations, the least problems are experienced by respondents in large metropolitan centres with 26.3% able to say that they have never had these problems. Even so, overall 83.72% of Queensland respondents reported experiencing problems with information received from hospitals about residents transferred to their care.

In the outer suburbs and regional centres respondents experience more frequent instances of poor information about residents prior to transfer. 92.59% of Queensland respondents in the regional category experience these types of problems and in the outer suburbs response with similar experiences is 85.71%. In country towns respondents report that overall, 78.95% have problems obtaining accurate and relevant documentation about residents prior to their transfer to aged care.

QLD	*Frequency of information problems about resident condition*					
Location of facility		3-4 times in six months	5-10 times in six months	Weekly	Never	**Total**
A large metropolitan centre	Count	13	1	0	5	19
	% category	68.42	5.26	0.00	26.32	100.00
	% of Total	15.12	1.16	0.00	5.81	22.09
In a large regional centre	Count	9	15	1	2	27
	% category	33.33	55.56	3.70	7.41	100.00
	% of Total	10.47	17.44	1.16	2.33	31.40

In a small country town or village	Count	10	5	0	4	19
	% category	52.63	26.32	0.00	21.05	100.00
	% of Total	11.63	5.81	0.00	4.65	22.09
In the outer suburbs of a city	Count	10	6	2	3	21
	% category	47.62	28.57	9.52	14.29	100.00
	% of Total	11.63	6.98	2.33	3.49	24.42
Total	Count	42	27	3	14	86
	% category	48.84	31.40	3.49	16.28	100.00
	% of Total	48.84	31.40	3.49	16.28	100.00

8.3 South Australia

South Australia's respondents indicate that most problems with resident information prior to transfer arise in larger centres where almost three out of four instances are problematic. In small country towns half of the respondents claimed not to have experienced problems with this aspect of hospital documentation.

SA ***Frequency of information problems about resident condition***

Location of facility		3-4 times in six months	5-10 times in six months	Weekly	Never	**Total**
A large metropolitan centre	Count	12	3	0	4	19
	% category	63.16	15.79	0.00	21.05	100.00
	% of Total	26.67	6.67	0.00	8.89	42.22
In a large regional centre	Count	4	2	0	2	8
	% category	50.00	25.00	0.00	25.00	100.00
	% of Total	8.89	4.44	0.00	4.44	17.78
In a small country town or village	Count	3	1	0	4	8
	% category	37.50	12.50	0.00	50.00	100.00
	% of Total	6.67	2.22	0.00	8.89	17.78
In the outer suburbs of a city	Count	3	4	1	2	10
	% category	30.00	40.00	10.00	20.00	100.00
	% of Total	6.67	8.89	2.22	4.44	22.22
Total	Count	22	10	1	12	45
	% category	48.89	22.22	2.22	26.67	100.00
	% of Total	48.89	22.22	2.22	26.67	100.00

8.4 Victoria and Tasmania

Victoria and Tasmania report significant problems with information provided by hospitals prior to resident transfer to their facilities with 97.59% claiming to have experienced these problems. From the table below it can be seen that in the large regional centres only two respondents say they had have never experienced such problems.

VIC/TAS	*Frequency of information problems about resident condition*						
Location of facility		3-4 times in six months	5-10 times in six months	Weekly	Daily	Never	**Total**
A large metropolitan centre	Count	18	8	4	0	5	35
	% category	51.43	22.86	11.43	0.00	14.29	100.00
	% of Total	18.37	8.16	4.08	0.00	5.10	35.71
In a large regional centre	Count	8	1	1	0	2	12
	% category	66.67	8.33	8.33	0	16.67	100
	% of Total	8.16	1.02	1.02	0.00	2.04	12.24
In a small country town or village	Count	14	4	1	1	5	25
	% category	56.00	16.00	4.00	4.00	20.00	100.00
	% of Total	14.29	4.08	1.02	1.02	5.10	25.51
In the outer suburbs of a city	Count	14	4	0	0	8	26
	% category	53.85	15.38	0.00	0.00	30.77	100.00
	% of Total	14.29	4.08	0.00	0.00	8.16	26.53
Total	Count	54	17	6	1	20	98
	% category	55.10	17.35	6.12	1.02	20.41	100.00
	% of Total	55.10	17.35	6.12	1.02	20.41	100.00

8.5 Western Australia

Most of the respondents from Western Australia are from metropolitan areas, either cities or outer suburbs. Around 25% are from large regional centres who claim to have experienced these problems at a rate of 77.78%.

In terms of experiences of problems with information provided about residents' condition prior to transfer, 85.71% of the metropolitan and 76.19% said they have these problems.

WA	*Frequency of information problems about resident condition*					
Location of facility		3-4 times in six months	5-10 times in six months	Weekly	Never	**Total**
A large metropolitan centre	Count	13	5	0	3	21
	% category	61.90	23.81	0.00	14.29	100.00
	% of Total	30.95	11.90	0.00	7.14	50.00
In a large regional centre	Count	6	0	1	2	9
	% category	66.67	0.00	11.11	22.22	100.00
	% of Total	14.29	0.00	2.38	4.76	21.43
In a small country town or village	Count	0	0	0	1	1
	% category	0.00	0.00	0.00	100.00	100.00
	% of Total	0.00	0.00	0.00	2.38	2.38

In the outer suburbs of a city	Count	6	1	0	4	11
	% category	54.55	9.09	0.00	36.36	100.00
	% of Total	14.29	2.38	0.00	9.52	26.19
Total	Count	25	6	1	10	42
	% category	59.52	14.29	2.38	23.81	100.00
	% of Total	59.52	14.29	2.38	23.81	100.00

8.6 Qualitative themes

49.6% (n=184) respondents commented on the information provided by hospitals about residents' condition prior to being transferred or admitted to residential aged care. A selection of these comments is shown below under several broad themes.

8.6.1 Apparent deception and false information provided on residents' condition

Many comments were made which portray the relationship between aged care and hospitals as being less than optimal and far from collegial.

Of particular concern to respondents are the many reports of hospitals refusing to provide essential information about a resident's condition and follow-up care, while citing privacy legislation as the reason for denying access to this information by professionals taking over the care and treatment of residents discharged from hospital. One facility reports being advised to seek the information through the Freedom of Information legislation which would have taken weeks to achieve and even then, perhaps would have been incomplete:

> *We have had residents come to the facility without any discharge information, no medications, no physio report and this makes our job more difficult. We have to telephone for information. One hospital I asked for discharge information after the person had arrived (next day) I was told that the chart had been sent to medical records and if I wanted any information I would have to access FOI.*
>
> *I have in the past been quoted the privacy clause in that no information can be exchanged however this is usually corrected by speaking to the social worker or NUM and is more relevant to existing residents being transferred to hosp for acute treatment*
>
> *No discharge notes at all. No pharmacy liaison. Never receive information after an emergency visit. Privacy legislation given as reason not to give information often.*
>
> *Reluctance to give information citing privacy legislation!*
>
> *Failure to advise of wounds or wound management, failure to advise of bowel activity, or treat constipation whilst in hospital. Over-sedation or non management of severe behavioural problems can be difficult to manage on resident arrival, especially in low care. Failure to advise of complex nursing procedures e.g. sub cut injections to continue on discharge. Families struggle without adequate (or no) information on treatment whilst in hospital and implications, and transfer letters do not always provide full outline of treatments/procedures or ongoing related care needs. Very difficult to obtain information prior to discharge, even when initiated by facility staff, as changing hospital staff result in difficulty finding some one to give full picture, and confidentiality seems to be applied to facilities even though they are the primary care providers on discharge.*

There is also a worrying perception by aged care personnel that hospital staff deliberately deceive them about the true condition of residents prior to transfer, in

the full knowledge that once a resident returns to the RACF they cannot appropriately be cared for. They also know that because of resident tenure provisions under the Aged Care Act 1997, aged care providers have no option but to do what they can for the resident because no other suitable place is available and hospitals will not accept them back even for short periods.

There appears to be a perception among respondents that hospital staff disregard the limited resources and capacity of RACFs to provide safe and effective care for residents who are known to hospitals as having serious and life-threatening illnesses, dangerous infections and violent psychiatric conditions, yet they are discharged anyway to the RACF with little information.

Infections

> *Resident returned to facility with hospital acquired MRSA, notification given to staff by ambulance transfer officers, nothing written on discharge papers. Resident returned to facility with untreated medical conditions. Resident returned to facility, Ambulance Officers advised us not to take this lady back as she could not be aroused, returned to hospital. Hospitals treat the symptom - not the cause. Resident admitted for a diabetic ulcer, diabetes not stabilised, hospital wanting to discharge refused to accept. In this instance Resident had toes amputated, family refused to have leg amputated resulting in death.*
>
> *Particularly MRSA status.*
>
> *Never told of MRSA, pressure areas, family difficulties.*
>
> *Sometimes hospitals do not inform us if a new resident has had diarrhoea or another hospital acquired infection whilst in hospital and the first we know about it is the discharge summary of the Ambulance officers tell us.*
>
> *One had incomplete diagnoses such that we would not have accepted the person had we had full information.*

Near death

> *In one case the resident was clearly palliative and we questioned the information from the hospital which indicated otherwise.*
>
> *One resident came back needing total nursing care on a Sunday afternoon, had been getting morphine in hospital for pain and none was sent back with him, no call was made to the facility to say he was coming back.*
>
> *Will not always provide facility with enough information for us to be aware of condition. Often not knowing death is near until resident has passed away. Often unknown that resident is to be classified for Nursing Home until it's already completed.*

Appropriateness of transfer

> *We have often found the condition of the client has been under-exaggerated allowing them to be admitted to the hostel.*
>
> *Information has not been complete re aggression and difficult behaviours. In one case we accepted a client whom we were told was not aggressive, but on the first day three staff were physically injured.*
>
> *Hospitals will sometimes gild the lily to ensure a discharge. E.g. a resident was alleged to be able to shower herself and ambulate independently as the hospital thought she was from our low care. In fact she was from high care and hadn't walked or showered herself for years!*
>
> *Resident unable to transfer or mobilise independently after discussion with hospital who informed me that the resident was independent with transfers and mobility.*
>
> *Often give misleading information to ensure resident is transferred. The local hospitals are ill equipped for confused clients and will deny dementia if no dementia care available.*

> *Resident not as mobile as told by hospital Resident incontinent on return to low care setting Resident has lost large amount of weight in hospital and was not followed up Resident has pressure areas and not informed prior to discharge.*

Accuracy of reports on resident health

> *If a patient has been in a transition bed for a number of weeks/months the information is often not updated to reflect their current capacity or their care needs.*
>
> *Status of a person's skin integrity is often not detailed and this has a significant impact on the type of mattress that the facility is required to provide to meet the resident's needs. Medical history is often understated, particularly in relation to residents suffering with dementia.*
>
> *No information provided on the wandering and other behaviours experienced whilst in acute care. Resident arrived in an unsecured facility and absconded several times per day and was aggressive without any management strategies implemented.*
>
> *Wounds, bedsores not reported. Difficult behaviours not mentioned.*
>
> *Care level inaccurate. Medical and clinical conditions omitted.*
>
> *We often receive very limited information on the resident. Very poor documentation and misinformed family members.*

From comments received there is also a perception that hospital staff are unaware of any difference between high and low care in RACFs, or perhaps that they do not regard the difference as noteworthy.

> *Usually poor information is received. Lack of understanding of aged care and the related issues in transferring residents particularly to low care facilities.*
>
> *The expectation that the PC's will be able to care for a resident who would/should have been in hospital for another few days due to medication management or wound care issues.*

Aged care residents have as much right to access the acute hospital system as do people in the general community so it is therefore not surprising that aged care facilities often act as advocates for residents whom they believe are being misled by hospital staff or denied appropriate access to hospital care:

> *Told by public hospital that family had stopped resident from having operation to repair hip following # NOF - family state the hospital refused to operate and resident would therefore be on 6 weeks bed rest - then get told few days later resident is able to use rollator with assistance of 1 staff. On arrival at RACF pain not managed - resident sent back to hospital following re-x-ray - bones far from healing.*
>
> *ACAT information does not give the facility the "right" information we need. I have had 3 residents who they have said are low care but our assessments show high care. I have had to be very insistent that they reassess these residents ASAP. They have not always being accommodating, but I have been right on all 3 occasions.*

8.6.2 Quality of information received about residents' condition

Respondents who volunteered comments in this theme expressed concern at the poor quality of information received from hospital and occasionally the unrealistic expectations of hospital staff expressed in documentation. The primary concern for aged care staff relates to risks shifted onto residents by unsafe hospital discharge. They also express concerns that their duty of care to residents may be compromised by lack of relevant information from hospital staff.

> *It is always difficult to gain information of new residents prior to admission. Information is usually limited to single word descriptions of residents such as continent, non-ambulant, etc. A detailed and*

comprehensive nursing or medical assessment is usually not included in the admission notes.

Some times the information that the hospital has given and what the family has given do not seem to be the same information. The impact of this is that the resident may not be suited the environment to have their needs met.

Occasionally information from hospitals is insufficient and convoluted and very difficult to read. Often fax copies of residents information is the only source of documentation.

On least 8 occasions we have been given the incorrect persons discharge letter. On 6 occasions where we have not received a verbal handover and the discharge letter has not been sent with the resident, then to be told by ward staff you will get it in the mail in the next 3 days. We have had to phone the registrar for information on care and medications. Residents often arrive without medications that hospital doctors have ordered - poses a problem when we have to wait for the GP to visit, write the script and send to pharmacy. This has taken up to 5 days of a dietician writing recommendations that we just can not achieve - individual meal to be cooked for that one resident! At times very short, vague nursing discharge information.

Information inaccurate on two occasions residents were transferred back unwell non-ambulating and we were told they were walking in hospital. Residents were previously low care and had bedrooms upstairs needed to be able to walk at least 50m to return. Our residents' health and safety are our top priority.

Information is inadequate or totally lacking. It seems that if the resident has a condition that the Hospital thinks might preclude him/her from coming back to the facility; we are not told about it. E.g. no longer weight bearing. We seldom receive any medical information, only nursing information.

Information is often withheld as the hospital is concerned the facility would not accept the resident. Difficult behaviours are often only partially noted and at times not at all. Difficult family dynamics are often not conveyed to the facility.

The problem we have in this area is that if a person has been transferred because of behaviour issues we NEVER get a behavioural management plan as part of the discharge summary.

Difficulties were also reported in relation to Aged Care Assessment Team (ACAT) assessments and their referral documentation:

The ACAT reports are usually the first contact we have with resident information. Sometimes this is not accurately completed and misleading (to our disadvantage). For example with wandering or aggressive behaviours the ACAT report will state that it is occasional whereas it should read regular or frequent.

Not always accurate and not always considerate of the limitations on aged care resources in relation to the care needs of the resident. The staff in hospitals do not understand the difference between low care and high care, and the need for ACATs.

ACAT assessments do not provide sufficient information for us to make a true judgement regarding client care.

The information from the hospital rarely matches reality, and Aged Care Assessments are frequently inaccurate to a large extent.

ACAT did not have up to date information on residents being transferred from acute care, several residents were admitted with infectious conditions the details of which where not mentioned until paper work was received when they arrived at the nursing home. One Resident had become an insulin dependent diabetic on an unusual type of insulin and was admitted without a supply of medication to stay him over until morning. The nursing

home was not informed of the type of insulin he was to receive until his admission which was late at night after the pharmacy closed.

Some times the ACAT form is all we get in relation to pre-admission information and it is often quite insufficient. Since working with one major acute hospital from which we take most of our admissions, this has improved. However we continue to notice the gap in relation to other hospitals and ACAT assessments.

Forty-four comments volunteered by respondents pertain to the poor quality and inaccuracies of information received about residents' condition, or the total lack of information provided to enable them to supply appropriate care and other services within the aged care home:

On many occasions, even though I felt the residents care would not be managed correctly at the facility, the resident has been discharged to us. On occasion, the discharge was on a Friday, and the resident was unable to weight bear, although this information was not handed over to us from the hospital.

Inaccurate, deficient information. Relevant information not included. No communication between staff within transferring service resulting different instructions.

Often no paperwork comes with them or if it does nothing about what happened to them whilst they were in hospital or the follow up required, particularly if the patient was already a resident of ours.

No Medicare card, pension card, medications. Really aggressive behaviour (physical) not mentioned +++.

Many information concerns relate to resident medical treatment and medication regimes. Usual practice for professionals transferring a patient on medical treatment is that they will provide accurate and legible documentation so that continuity of care and patient safety is safeguarded. Large numbers of aged care industry respondents have not found this to be standard practice in relation to hospital discharge of older patients to residential aged care. Some typical responses are:

At times we don't even receive medication summaries or even a transfer letter. A lot of times someone will ring whenever & give brief details of patient. A care plan summary with the transfer letter would be wonderful as if they don't have families we can end up with practically no information.

Often medication unclear. Last dosage of medication unclear. If you get onto right person it is usually ok.

Discharge summaries (we get the third layer of carbon copies) are almost impossible to read and they lack detail; little in the way of nursing information included unless we contact them personally.

Staff state that they are still waiting for the doctor to review and therefore provide little information on there condition. Our facility rarely receives a discharge summary and if we do it provides little information.

Information not always provided, especially relating to allied health services, speech pathology and physio.

Rarely do you ever get information about what went on in the hospital (tests/results/treatments/drugs/etc).

Sometimes discharge letters are not provided by medical staff and we must spend time chasing up. Occasionally there are discrepancies in information given by different health professionals from the hospital.

New medications prescribed - not informed.

Many times nil or informative feedback is given to the Aged Care Facility. Medication changes are very important as most Facilities have a different system re Medication Management and are always chasing MO's to rechart for Medication Administration at the Facilities.

In the majority of incidences one or other (medical/nursing) of the discharge summaries are missing. We have an instance in the last six months where incongruence was evident between the patient details on each page of the notes, prescriptions did not match the summary of "Medications on Discharge", and not to mention the total absence of one long term medication for (condition) result the GP omitted the one crucial drug.

Information is not always clear...e.g. just this week a resident returned from a hospital stay. Discharge summary explained that resident went in with a bowel obstruction. The previous day had been on IV antibiotics for an infection they could not track. There was no mention of this in the notes.

Changes to residents medications not complete e.g. medications that they have been on for long periods not mentioned in discharge summaries therefore you do not know if they have been ceased or not Changes in mobility and eating not mentioned.

Discharge summaries are scant and do not cover all areas of treatment. They do not give explanations as to medication changes.

Many times nil or informative feedback is given to the Aged Care Facility. Medication changes are very important as most Facilities have a different system re medication management and are always chasing MO's to rechart for medication administration at the facilities.

Often difficult getting correct information on medications or resident condition.

It seems that even when contacted by aged care staff, hospital nurses have little or nothing to add in relation to details about residents whom they have transferred to RACFs:

Hospital discharge planner or ward staff not giving accurate information about resident's condition.

Information provided is not comprehensive and usually relates just to the immediate condition for which they were admitted.

Transfer information usually very brief and concentration mostly on acute condition. In some cases very limited information.

Nursing staff usually don't know much about person or what problems are, medications etc.

8.6.3 Methods of information transfer

Some respondents commented that information is transferred appropriately but others think the quality and amount of information transferred depends on the mood or motivation of hospital staff to provide reliable information:

They [hospital] always ring and provide us with a handover.

The local hospitals have definitely become better at this. There is usually one person who will ring through and inform you.

Information has been faxed in advance which has allowed staff to query anything prior to residents transfer.

Dependent on motivation of staff at Hospital.

Depending on which staff are on duty when they are transferred back determines how much, if any, info is given to us. Sometimes there is no documentation and we do not know what they have done from the hospital end.

Happens to 90% of discharges. Discharge papers from [local hospital] do not exist! [Regional hospital] can be variable but no one seems to care.

Often medications unclear. Last dosage of medication unclear. If you get the right person is usually OK.

There seems to be little consistency in hospital policies and practice in relation to information on medical, nursing, therapy or other follow-up needed following a hospital stay:

> *Usually minimal info given - no yellow envelopes returned, info comes back two or three days after arrival back at RACF, or we have to chase the info up. If someone comes back from the ED, they often don't have any info as to what happened at ED (or the ED rings us and asks us what the problem is, after we have sent heaps of info to them).*
>
> *Resident suffered a heart attack whilst in Hospital. No information on discharge summary re this. Information via relatives. Minimal information on other discharge summaries.*

Respondents clearly believe that for the benefit of residents caught in this situation, it is up to them and the aged care home to compensate for deficiencies in information provided by hospital staff that might assist continuity of care for residents being transferred.

> *Often need to ring hospital to check.*
>
> *Problems arrive because hospitals only send Nursing Notes with the resident. Medical notes and medication changes is usually sent to the GP and Nursing staff have to chase the information required.*
>
> *Often no information is sent with the resident. We have to phone and ask for information. No medication list is sent and no actual medication sent either.*
>
> *Resident sometimes comes back with only a nursing transfer letter and no medical discharge letter and sometimes the 2 letters are in conflict so we have to telephone the ward to clarify care needs and or medication.*
>
> *Recent experience resulted in a resident arriving back from Acute Care - no transfer information, only a list of most recent medications, family provided information on most recent care. When hospital was contacted couldn't find anyone who knew the care of the resident.*
>
> *Residents arrive at facility with no discharge paperwork, which is then chased up by facility staff, causing much extra work, and lag time in providing appropriate care.*

8.6.4 Hospital assessment and care handover issues

From comments volunteered in response to the survey, it appears that aged care staff are not confident that hospital personnel are able or willing to conduct an accurate assessment of older people, or to provide sufficient information to effect an appropriate handover of care and treatment of residents. The comments shown below reflect their experiences of hospital assessment efforts as well as handover of care and treatment information to ensure resident safety:

> *Hospitals think all residents are from the nursing home, have no idea of semi-independent residents in Hostel, therefore want to transfer a resident with high care needs and frequent staff attention required e.g. assistance with mobilisation to toilet. Conflicting reports from hospitals on condition within a space of a few minutes from different staff e.g. discharge planner says independent with mobilisation but ward staff say 1:1 assist.*
>
> *Not enough relevant information given to nursing staff from the hospital. The staff at the hospital do not see it as relevant for our needs.*
>
> *We need accurate information regarding mobility, any special diet, activities, follow-up appointments, any significant dressings, pain management, diets, cognitive/mental state, are there any concerns re resident safety.*
>
> *Resident's condition has changed and not suitable for low care facility. No high care needs assessment is done before discharge.*

Unless requested, we never receive nursing or medical summaries of the patients before transfer to give a more detailed picture of the resident. And even then the information is so brief that it's almost useless.

Residents often arrive with dressings, wounds etc not mentioned in transfer documents or discussed with hospital staff.

Transfer letter did not contain information relating to treatment provided and needing continuation No details of follow up OPD appointments No details of medications to be continued.

We have had residents with incorrect diagnosis, incorrect medications, residents transferred from another area and the doctor they have designated is unaware he has been selected by the family which has delayed medication arrangements etc for ongoing care.

When phoning us the intake officer asked for information and the caller said they did not have the notes in front of them - they were just told to ring us.

Transfer forms do not indicate what investigations have been undertaken, i.e. X-rays, blood tests, urine testing etc. On return they may be ordered the same tests simply because information was not at hand and the treating GP might not be familiar with the person's treatment and/or investigations while in hospital.

Again does not occur with all transfers. However, the transfer letter information from acute hospitals is inadequate to admit and care residents in an Aged Care facility.

On nearly every occasion there has been no return of yellow envelope, no discharge summary and no medication orders. Resident sent back for palliative care but medication orders remained the same as prior to admission. Had to get a GP to come and cancel orders and write morphine up etc.

8.6.5 Recommended strategies to improve pre-transfer information on residents

Respondents also provided strategies that they use to resolve difficulties in obtaining an accurate and timely account of residents' condition prior to transfer from hospitals. Overall it appears that it is up to the RACF to initiate contact with hospitals and to make resources available to retrieve information needed to provide residents with appropriate care and treatment.

Do a pre-discharge hospital visit for longer hospital stays. Pre-admission visit for all new residents in a 300km radius.

Staff in aged care setting can access Hospital Medical file if required, as well as transfer notes from acute staff.

Hospital staff are unfamiliar with the information needed and in some cases that any information is required. I attend weekly Care Providers meeting at hospital so on that day we are well informed and in some cases fore-warned but there is a gap in information from hospital to aged care service.

On all occasions there has either been NO information or scanty information. We have the information verbally from previous contacts but have to contact the hospital (mostly the public system) to obtain the information - usually from the medical records department.

I am meeting with the private hospital DON to improve this. I am also meeting with one of the GPs at a different time tomorrow.

We usually get a telephone report followed by a short summary and list of medication - we phone for in depth information.

Communication and fortnightly ACAT meeting provide an overview of the resident's condition.

Very often, resident's condition is not clearly explained to staff, resulting in residents returning to a facility (particularly low care) with higher levels of

care required. Have found that many hospitals now have electronic discharge summaries for medical information which can be quite effective, but nursing information can sometimes still be lacking.

The resident often arrives with no medical discharge papers and we then have to ring hospital and ask them to fax to us.

Each time a patient is being transferred to our facilities, I send a staff member from the facility to ensure complete information - taking care time away from the current residents of the nursing home.

Sometimes we get scant details and staff make several phone calls to get appropriate information.

We 'age in place' here so we can usually manage and we try to keep our residents within our facility whenever safe. We are a low care and high care facility.

8.7 Summary and recommendations

Reports on resident care and treatment are prominent documents in the professional approach to people requiring acute hospital services. It is difficult to imagine that these documents do not exist or that meticulous records are not kept of the medical, nursing and other services received by patients. Yet this is the impression given by hospitals around Australia to the respondents in this survey.

They have expressed concerns about the attitude of hospital staff towards older people; the veracity of their words and dealings with aged care providers; and the competence of hospital staff in even the most basic of care and management tasks. It has even been suggested that the level of conscientiousness and professionalism of doctors and nurses in hospitals depends on the mood they are in at the time.

The consequences of such perceptions being held about hospital staff lie in the creation of an almost insurmountable hurdle preventing effective collaboration that would benefit older people who are in no position to adjudicate. When residents return home with drug-resistant infections, life-threatening conditions, no medications, no indications of care or treatment, and near death, the prospect of trying to locate a doctor or nurse who might be willing to talk to them, and who might know something about the resident, can be daunting for aged care staff.

8.7.1 Recommendations

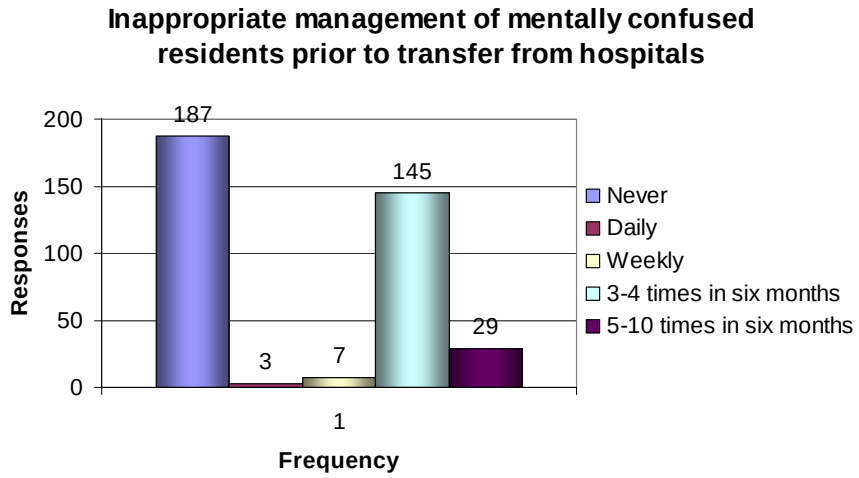
Anticipate and prevent problems. Pre-discharge hospital visits allow aged care staff to gather accurate information and discuss care issues with staff who may know the resident.

Raise hospital awareness of aged care. Set up regular liaison meetings with ACAT and hospital staff.

Cost recovery. Estimate costs of aged care resources needed to compensate for hospital deficiencies and negotiate cost recovery arrangements with hospital management.

9 Appropriate management of mentally confused older people prior to transfer to aged care

Of the 371 respondents, 50.4% (n=187) claim that they have no issues with the way hospitals managed mentally ill or confused residents while in their care. Even so, around 1:3 people who completed the survey report some difficult experiences in this area of resident transfers from hospital.



Hospitals are set up to deal efficiently with acute health problems and the environment in which medical and other services occur has inherent risks for anyone who is not in a position to interpret what is happening. When we add to this situation some perceptual limitations arising from normal ageing processes it is unsurprising that older people can find hospitals to be uncomfortable and confusing places. In this question, aged care respondents were asked if they have had experiences of advocating for mentally confused residents who required acute hospital services and in particular, whether they have experienced any problems arising from hospital treatment of mentally confused residents.

9.1 New South Wales

NSW	***Frequency of problems in managing mental confusion***					
Location of facility		3-4 times in six months	5-10 times in six months	Daily	Never	**Total**
A large metropolitan centre	Count	8	4	2	25	39
	% within category	20.51	10.26	5.13	64.10	100.00
	% of Total	8.00	4.00	2.00	25.00	39.00
In a large regional centre	Count	9	2	0	9	20
	% within category	45.00	10.00	0.00	45.00	100.00
	% of Total	9.00	2.00	0.00	9.00	20.00
In a small country town or village	Count	5	1	0	5	11
	% within category	45.45	9.09	0.00	45.45	100.00
	% of Total	5.00	1.00	0.00	5.00	11.00

In the outer suburbs of a city	Count	8	3	0	19	30
	% within category	26.67	10.00	0.00	63.33	100.00
	% of Total	8.00	3.00	0.00	19.00	30.00
Total	Count	30	10	2	58	100
	% within category	30.00	10.00	2.00	58.00	100.00
	% of Total	30.00	10.00	2.00	58.00	100.00

It is clear from the above table that in NSW, large metropolitan centres and outer suburbs provide services much more attuned to the needs of confused elderly people than in regional areas or small towns. 64.10% of respondents in metropolitan areas said that they have never experienced any problems with the treatment of mentally confused residents. As well, 63.33% from the outer suburbs made similar claims.

In regional and country areas the high number of respondents who said they have never experienced such problems is somewhat less than for city areas. 54.54% in small towns and 55% in regional centres state they have indeed had problems with the way their mentally confused residents are treated in hospital.

While these indications of good or better care are encouraging, it is important to realise that just under half of mentally confused residents referred to by respondents are not treated well during their hospital stay. If just one vulnerable older person is disadvantaged by staff employed to care for them, it is one person too many. Comments received from respondents provide a startling insight into their observations and views about hospital treatment of confused older people and in particular, those residents who go to hospital to access acute medical services that cannot be provided by the RACF.

9.2 Queensland

The Queensland situation shown below, in relation to mentally confused residents and hospital care, indicates that suburban areas as most likely to be unproblematic with 57.14% claiming that they have never experienced problems in this regard. The next most positive location is in small country towns however it seems that some have quite frequent issues with hospitals so possibly much depends on what is happening locally.

QLD	***Frequency of problems in managing mental confusion***					
Location of facility		3-4 times in six months	5-10 times in six months	Weekly	Never	**Total**
A large metropolitan centre	Count	9	1	1	8	19
	% category	47.37	5.26	5.26	42.11	100.00
	% of Total	10.47	1.16	1.16	9.30	22.09
In a large regional centre	Count	12	3	0	12	27
	% category	44.44	11.11	0.00	44.44	100.00
	% of Total	13.95	3.49	0.00	13.95	31.40
In a small country town or village	Count	7	2	1	9	19
	% category	36.84	10.53	5.26	47.37	100.00
	% of Total	8.14	2.33	1.16	10.47	22.09

In the outer suburbs of a city	Count	7	1	1	12	21
	% category	33.33	4.76	4.76	57.14	100.00
	% of Total	8.14	1.16	1.16	13.95	24.42
Total	Count	35	7	3	41	86
	% category	40.70	8.14	3.49	47.67	100.00
	% of Total	40.70	8.14	3.49	47.67	100.00

9.3 South Australia

South Australian respondents appear to have more problems with large regional centres (87.50%) than other locations although metropolitan centres (68.42%) are also experiencing significant levels of difficulty with the way hospitals approach the care and treatment of mentally confused residents needing acute hospital services. A similar pattern exists in small country hospitals where only 37.50% are able to say they have never experienced problems with the way their residents are being managed and cared for in hospitals.

The implications of so many respondents believing that the standard of care for this resident group is not as it should be are that systems and protocols between aged care and hospitals may need urgent attention and improvement.

SA	***Frequency of problems in managing mental confusion***				
Location of facility		3-4 times in six months	5-10 times in six months	Never	**Total**
A large metropolitan centre	Count	12	1	6	19
	% category	63.16	5.26	31.58	100.00
	% of Total	26.67	2.22	13.33	42.22
In a large regional centre	Count	7	0	1	8
	% category	87.50	0.00	12.50	100.00
	% of Total	15.56	0.00	2.22	17.78
In a small country town or village	Count	4	1	3	8
	% category	50.00	12.50	37.50	100.00
	% of Total	8.89	2.22	6.67	17.78
In the outer suburbs of a city	Count	2	3	5	10
	% category	20.00	30.00	50.00	100.00
	% of Total	4.44	6.67	11.11	22.22
Total	Count	25	5	15	45
	% category	55.56	11.11	33.33	100.00
	% of Total	55.56	11.11	33.33	100.00

9.4 Victoria and Tasmania

In comparison with results from other States, respondents from Victoria and Tasmania were more able to say that they have never experienced problems with the way their mentally confused residents are treated or cared for in hospitals. 80% from small towns and 50% in both large regional centres and outer suburbs have never had such problems.

From the table below it appears that most difficulties are linked to dealings with large metropolitan centres where experiences of problems in relation to mentally confused residents occur more overall (60%) as well as more frequently.

VIC/TAS		*Frequency of problems in managing mental confusion*					
Location of facility		3-4 times in six months	5-10 times in six months	Weekly	Daily	Never	**Total**
A large metropolitan centre	Count	18	2	1	0	14	35
	% category	51.43	5.71	2.86	0.00	40.00	100.00
	% of Total	18.37	2.04	1.02	0.00	14.29	35.71
In a large regional centre	Count	3	2	1	0	6	12
	% category	25.00	16.67	8.33	0.00	50.00	100.00
	% of Total	3.06	2.04	1.02	0.00	6.12	12.24
In a small country town or village	Count	3	0	1	1	20	25
	% category	12.00	0.00	4.00	4.00	80.00	100.00
	% of Total	3.06	0.00	1.02	1.02	20.41	25.51
In the outer suburbs of a city	Count	12	1	0	0	13	26
	% category	46.15	3.85	0.00	0.00	50.00	100.00
	% of Total	12.24	1.02	0.00	0.00	13.27	26.53
Total	Count	36	5	3	1	53	98
	% category	36.73	5.10	3.06	1.02	54.08	100.00
	% of Total	36.73	5.10	3.06	1.02	54.08	100.00

9.5 Western Australia

In Western Australia respondents on this issue are from large metropolitan centres. Of these over half (52.38%) have had difficulties in this regard. The other two areas where problems have been reported are in large regional centres (66.67%) and suburban areas (45.45%).

WA		*Frequency of problems in managing mental confusion*				
Location of facility		3-4 times in six months	5-10 times in six months	Weekly	Never	**Total**
A large metropolitan centre	Count	11	0	0	10	21
	% category	52.38	0.00	0.00	47.62	100.00
	% of Total	26.19	0.00	0.00	23.81	50.00
In a large regional centre	Count	4	2	0	3	9
	% category	44.44	22.22	0.00	33.33	100.00
	% of Total	9.52	4.76	0.00	7.14	21.43
In a small country town or village	Count	0	0	0	1	1
	% category	0.00	0.00	0.00	100.00	100.00
	% of Total	0.00	0.00	0.00	2.38	2.38

In the outer suburbs of a city	Count	4	0	1	6	11
	% category	36.36	0.00	9.09	54.55	100.00
	% of Total	9.52	0.00	2.38	14.29	26.19
Total	Count	19	2	1	20	42
	% category	45.24	4.76	2.38	47.62	100.00
	% of Total	45.24	4.76	2.38	47.62	100.00

9.6 Qualitative themes

127 respondents provided comments on the issue of concern related to the care of mentally confused people who need hospital services. A selection of comments typifying responses is shown below under broad themes:

9.6.1 Rarely experienced difficulties or never at all

Most respondents are able to say that they have no problems with the way mentally confused residents are treated while in hospital. These responses indicate that a system of effective communication is in place with the hospital, treating doctor or mental health teams to deal with any anticipated problems and to remedy issues that arise:

> *Only one episode of a new admission arriving at the facility that was not stable mentally. The facility followed up with the hospital and the situation was sorted for future transfers.*
>
> *Not a big issue for us as generally our local doctors are in agreement with our policy that admission of the confused to hospital unless absolutely necessary with treatment occurring at our service. We are a low care with ageing-in-place (70% high care now) with a secure dementia unit. Doctors and staff work effectively for the resident, as a team.*
>
> *Most often it has been reasonable.*
>
> *Usually hospitals take appropriate management procedures of mentally ill, confused patients we have required to transfer.*
>
> *Supportive mental health team.*
>
> *Local M.P.S. manages well. Base Hospital seems not to manage as well.*
>
> *Nil issues, usually appropriate management is evident, however sometimes acute hospitals are poor at identifying increased confusion with a resident who already has some form of dementia.*

9.6.2 Inappropriate management and care of dementia

The remaining one third of respondents who provided comments on hospital management and treatment of mental confusion are critical of what has been done to, and for, the resident while in hospital:

> *Residents suffering dementia not given individual attention during meal times, meals put on trays with food covered, residents not able to recognise food. Food not cut up for residents suffering dementia. Resident suffering from dementia refusing to get into bed, when visited by staff from this facility, the wrong name was on the top of the bed. One female resident felt violated after insertion of catheter for no obvious reason. Continence pads placed on chairs, residents sat on pads, no underwear. Visited one resident who begged me for a drink from the toilet bowl as she was so thirsty. She was prescribed thickened fluids, when I went in search for thickened fluids was told none on the ward. Visited resident who had a large prolapse, she was in great pain, she was restrained in a chair by a table top, unable to move begged me to lay her on the bed to relieve pain.*

> *Usually increased "dementia" is due to being moved around, being unwell and disoriented.*
>
> *Particularly a problem in Accident and Emergency, and appears to contribute to early discharge back to the facility with incomplete treatment. Pain management does not seem to be assessed well in confused/demented residents with over sedation or inadequate pain control. Lack of attention to ADLs e.g. hygiene, continence management and nutrition when residents are unable to initiate, and/or non compliant.*
>
> *When they have documented evidence resident has some confusion and memory loss, but seek their cooperation to make decisions on care or arrange discharge without involving family or facility e.g. sending confused 94 year old woman back at 5.30pm in the front seat of a cab, wearing only a thin nightie.*

<u>Routine sedation and use of physical restraint</u>

Aged care staff practice within a model of care that respects and optimises older people's self-determination and dignity, even when some mental confusion is present from whatever cause. It is distressing therefore for them to observe residents for whom they have provided dignified care, being controlled for the convenience of hospital staff rather than the residents' needs:

> *They [confused residents] will usually be transferred back on far more medication than prior to admissions. The most distressing thing for staff is that they go visiting and the horror stories of restraint being used in the hospitals. Seems the acute sector operate under very different legislation to aged care. Staff then need debriefing.*
>
> *Any resident with a degree of confusion is managed inappropriately and generally with physical restraint.*

The use of chemical restraint as both preventive and responsive measures to control potential as well as actual confused behaviours in older people seems to be so widespread in hospitals as to seem almost routine to some respondents:

> *Hospital staff will phone to ascertain the cognitive function of the person even though all relevant information has been included in the transfer information from the facility. Residents are often medicated to assist hospital staff to manage the confused person and the resident will often return to the facility in a 'drowsy' state. They use physical and chemical restraint much more than aged care facilities. Send back on sedation which is not necessary.*
>
> *90% of transfers are inappropriately medicated. Families request restraint because hospital told them it is only way to manage wanderers.*
>
> *Heavily sedated on arrival (staff not informed) episodes of physical violence from resident when medication wearing off.*
>
> *Residents heavily sedated so that no behaviours are apparent.*
>
> *The relatives often complain that their resident who is confused in hospital is ignored or sedated to control them.*
>
> *The patients are medicated rather than receiving 1:1 time by staff.*

Even where aged care staff have provided information on managing confused residents while in the hospital, there is evidence that this information is ignored even when confused behaviours commence as a result of disturbed routine:

> *Our facility takes great care to document effective interventions for residents with challenging behaviours, only to have distressed relatives return to the facility stating that their loved one was tied in the bed/chair and very anxious. For example we do use doll therapy in appropriate situations on the occasion of a resident transfer to hospital we detailed "Baby's routine" and the cues for when to implement the intervention; the resident's daughter was told on arrival at the Ward that her mother had been physically aggressive and upon entering the room found her mother*

> *weeping, restrained in bed. "Baby" was found stuffed in the bottom drawer of the bedside locker, upon being reunited "baby" and resident settled quietly.*

The effect on families of seeing their elderly relative sedated and physically restrained in hospital has a subsequent influence on their perceptions of the care given by aged care staff.

> *Restraint is commonly used in the acute sector to minimize wandering and families subsequently struggle to understand why we do not use restraint - either physical or chemical unless all other options have been tried.*
>
> *Acute facilities often use restraint (bed rails). This facility has a no restraint policy, that is, we use the least dangerous alternative (no bed rails), and we just lower the bed and pad the floor. Regardless of the danger to the client, the relatives often want bed rails up like they were in hospital.*

It also seems to be common practice for residents with mental confusion to be sedated prior to transfer back to aged care facilities. When combined with issues identified earlier in relation to delays in ambulance services and the long trips that occur with ambulance transport, risks become obvious in relation to safety and dignity of residents whose capacity for self efficacy has been further compromised by chemical restraint applied prior to leaving the hospital.

> *Residents often come back sedated (so they can be managed in the acute facility) residents come back scared, frightened and at great risk of falling.*
>
> *Chemically sedated and often transferred back to faculty before they should be.*
>
> *The elderly resident is not prepared and is often sent by the hospital and their confusion increases or they are sedated for the transfer.*
>
> *Residents often over medicated on return and have been physically restrained in the acute hospital.*
>
> *Often the resident is unable to respond effectively, have been medicated prior to transfer or are very confused and agitated on arrival and require 1:1 time for an extended period to settle.*

Routine urinary catheterisation

Several respondents commented on an apparent routine practice of inserting urinary catheters into confused older people, along with chemical restraint, to control any anticipated behaviours that might arise while the person is in hospital:

> *Residents who have dementia or confusion come back heavily sedated and this places them at risk of falling. Takes days sometimes for the resident to wake. Also they are catheterised in hospital and it takes time to retrain them as they may have been fully continent before the admission.*
>
> *Concerns re: insertion of catheters seemingly routinely, over sedation on arrival at hospitals.*
>
> *Secure unit continent resident admitted for day care eye operation. Stayed in overnight. Due to confusion and the new layout he was incontinent. Resident was catheterised which added to his confusion. Since return is now continent again.*

9.6.3 Resident access to hospital and appropriate mental health services

A commonly reported issue within the aged care industry across Australia is the difficulty associated with accessing mental health services for older people. Too often, mental health issues are declared to be 'dementia' even without any assessment or investigation as to the cause of the symptoms being manifested by the older person. There seems to be little appreciation by medical and nursing staff in hospitals that mental health issues and organic brain disorders have quite different aetiologies which determine appropriate treatments and interventions.

The major problem identified by respondents is resident access to skilled assessment while in hospital:

> *Poorly managed, no plan put in place, mental health care plan developed after call from facility. Some residents can be suicidal.*
>
> *Hospitals are very reluctant to admit residents with psychiatric problems.*
>
> *Sending residents back to facility without being properly assessed for changes in their confusion. It is often thought that because they are old or have dementia they are always confused. Some hospital staff not willing to listen to staff who know the residents well.*
>
> *Hospitals think all confusion caused by dementia. Dementia residents seen as not appropriate to acute care.*
>
> *Resident sent in due to challenging behaviour and gets sent straight back with common diagnoses of UTI.*
>
> *Often hospitals want to return demented residents very quickly without thorough investigation.*

A further problem relates to inappropriate and unsafe hospital discharges of confused residents:

> *One resident with acquired brain injury was discharged from emergency via taxi. He was later returned to facility via police car as he was wandering around the streets.*
>
> *Hospitals often do not want to hold residents who are mentally confused so they immediately send back to the aged care facility & they are sometimes not suitable to be nursed in the low care hostel accommodation they were previously housed in .They assume that because we have both high & low care that all areas are staffed with maximum numbers of staff.*
>
> *Cognitively impaired residents are often fast tracked back to our facility due to their behaviour in hospital. Several were discharged prematurely & hence made management difficult back at our facility.*

Part of the issue is the rapid processing by hospitals of patients who have dementia symptoms, who were transferred to hospital because of their health problems rather than any symptoms of dementia which are often not the reason for seeking hospital treatment:

> *We find residents with dementia are often returned to facility quicker then others.*
>
> *Not full disclosure of the resident's condition especially in relation to violent behaviour.*
>
> *Residents with dementia arriving back to the facility by taxi and unescorted.*
>
> *Bouncing them back, no notification, no paperwork, and no contact name.*
>
> *Not correct information supplied about aggressive behaviours, medications often inadequate.*
>
> *No consultation regarding the needs of the resident. Residents are often sent back due to their confusion with little or no treatment.*

9.6.4 Confidence in hospital staff psychogeriatric skills

It is not surprising that respondents who have experienced difficulties in advocating on behalf of mentally confused residents needing hospital treatment, have formed a view of hospital staff competence in terms of psychogeriatric skills and knowledge of normal ageing processes. In fact, some comments imply a judgement of hospital care as posing risks to people who are not in a position to self-advocate. Many comments volunteered by respondents on this issue are typified by those shown below:

> *Staff in Hospitals appear to have little knowledge of how to manage confused older people. Comments about behaviours and management of*

> *same are usually inappropriate. The general impression is that the resident needs to be out of the hospital system as soon as possible. I would agree with that for the residents' sake.*
>
> *Generally speaking, mentally confused older people are being cared for in high acute hospital beds. This is not appropriate for them and only adds to their confusion. Staff do not have the time or insight to meet their needs effectively and residents frequently are returned to the facility with mobility problems, dehydration, malnutrition and urinary tract infections. They also invariably have sustained skin tears through falls or have pressure areas sustained by being physically restrained or discouraged from mobilising.*
>
> *Acute hospitals - doctors do not know how to manage mentally confused elderly, nor anything about medications; or palliative care.*
>
> *Hospital staff do not have experience or expertise when dealing with mentally confused people. Would rather return them to facility than treat at hospital as they cannot deal with them safely.*
>
> *With all due respect, and generally speaking there is little to no understanding of how to care for or manage resident with dementia. This is especially evident in the early stages when they act in a seemingly appropriate way and say they have had a shower and have not, or taken their medications and have not.*

Aged care staff responding to the survey express a lack of confidence in hospital staff ability and even their willingness to provide health services to people who are not fully cognisant. Some respondents recommend further education of hospital staff in aged care approaches and appropriate assessment and management of confusion:

> *They need to be educated in caring for someone with dementia, so as they don't speak abruptly to residents. Telling us to physically restrain a resident is not an answer. As it's not practice that we do as first line management.*
>
> *Many of the phone calls from hospitals regarding the resident have in fact been about behaviour management. The staff at the hospital require much more training in behaviour management, and not try to discharge back home because of difficult behaviours.*
>
> *We often get calls from different staff on different shifts requesting information in how to care for a particular resident. Often they will send a resident back due to inability to manage their behaviour.*
>
> *Staff do not seem to know how to appropriately manage mentally confused older people. They are returned to the facility usually within the same day as transfer to the hospital, because they do not know how to manage.*
>
> *As acute staff are not experienced in the care of mentally confused elderly the patient is transferred in a rush with little or no medical information.*

Respondents also observe that hospital nurses and doctors lack skills in assessment related to mental confusion and interpreting behavioural symptoms:

> *I think we all know that hospitals don't manage residents who have dementia well.*
>
> *Delirious patients should not be transferred to aged care but often are.*
>
> *The problem mostly arises if the resident comes from outside our town and we have to find another GP to care for the resident. Mostly acute hospitals do not have the same level of understanding of mental confusion in the elderly and it takes a little time for the residential care staff and new doctor to stabilise the resident.*
>
> *Often poor level of assessment of behaviour/mental state.*
>
> *Not given accurate information about person behavioural problems. Obvious increased confusion not seen as an acute issue but rather, due to old age.*

> *Sometimes they do not keep long enough to be stable medically because of staff difficulty in coping with behaviours.*
>
> *Handled poorly by the hospital. The Mental Health division does manage effectively or have a robust discharge plan.*
>
> *People in acute care have very little insight/knowledge how to care for people suffering from dementia.*
>
> *Depression is often not picked up at hospital until arrival at the facility.*

Even families notice the paucity of appropriate skills or approaches by hospital staff to their confused relatives while in hospital:

> *Relatives have reported that acute care hospital staff do not appear to have the time or in most cases the skill to manage their confused older relative (our resident).*
>
> *Families pleased when residents return home.*

Sometimes assessment occurs, however the outcome may or may not be appropriate:

> *These people have been kept by the hospital, reassessed by ACAT and transferred to a high care facility when they could have come back.*

9.6.5 Partnerships in care of confused and mentally ill residents

Respondents show a keen interest in having systems and protocols in place to safeguard residents and provide access to appropriate services for their health or psychiatric needs.

Some comments identify impediments to setting up effective care and treatment partnerships and these include issues discussed previously, such as communication for continuity of care:

> *There are more residents with mental illnesses being admitted to facilities. There is very limited backup if things go wrong. In fact we have been put down by medical staff for asking for help.*
>
> *My experience is with people with mental illness who appear alert and give incorrect information to the hospital which is used inappropriately. Facility information is not sought.*
>
> *Hospital has presumed that having a coded area deems us appropriate to take extremely violent and physically able residents putting our existing residents and staff at risk. This has caused extreme problems for local police ambulance staff and other residents families. In one case, the transfer summary did not indicate the extreme nature of the residents' psychiatric problems and had not been seen by a geriatrician pre admission.*
>
> *Limited understanding of the ability of the facility to cope with certain psychiatric behaviours in the facility especially in regard to the effects on the other residents if they are very demanding of staff's time, the facility's resources and the satisfaction of the relatives involved.*
>
> *This facility only deals with residents who have mental illness so the need for a more detailed discharge summary is vital in providing appropriate care.*
>
> *Many barriers faced with residents undergoing treatment from Psychiatric Units, communication is very confusing and unorganised.*

Some respondents are strongly of the view that hospital staff will say anything to aged care providers in order to move older patients with mental illness out of the hospital system regardless of the capacity of aged care services to provide appropriate psychiatric care and treatment:

> *No communication in relation to suitability with resident's mental and physical conditions as they have no idea about the facility's capacity to*

handle with environment and staff level in low care facility in ageing in place.

Basically, they have no idea what we require in terms of support and accurate information. They seem to deliberately play down significant behavioural issues.

Confusion often greater than exhibited in hospital when resident is transferred to a facility as in hospital they have had a 1 on 1 nursing care.

Not given accurate information on behaviour management experienced in acute care stage.

This is an ongoing issue. What we are told is the issues of the resident and what the resident actually has is often very different. E.g. not informed that they are wanderers, aggressive etc.

We never get a behavioural management plan as part of the discharge information. We do not get clear messages re absconding vs. wandering clients.

Aged care providers do accept residents with mental illnesses but they also need to know the extent of an incoming resident's needs so that appropriate arrangements can be put in place to provide that care:

The fact that a person is mentally confused and therefore "difficult to manage" in hospital can speed up the need for transfer back to the facility at the expense of medical treatment. Some residents have been commenced on medication to "manage" mental confusion that can be managed non-pharmacologically in the RACF.

There is usually no behaviour management strategies developed and generally no effort has been made to identify triggers. No differential diagnosis or cognitive assessment has been done prior to transfer.

Families are also not always fully or accurately informed by hospital staff of the person's condition or the level of services available in aged care. Some comments indicate that this lack of hospital information could be a deliberate attempt to ensure that the resident transfer occurs:

Reported that often no information is forthcoming as it seems hospital staff are fearful of disclosure holding up transfer/admission.

There seems to be no real preparation of confused people to coming into the facility and often the families have had no real preparation.

Resident arrives back with no information regarding when last had fluids, food, toileted. etc. Incontinent, not appropriately dressed.

Often confused residents are given verbal orders before being sent to RACF and no written information.

A resident was transferred to an acute facility in a terrible mental state for review and was returned to our facility in a worse state. She was transferred straight back.

Residents have been returned to facility with increased confusion without comments in discharge notes.

A few comments were made as to hospital staff ignoring information provided by aged care homes that would have assisted in assessments and management of confusion:

Hospital staff do not read the information that we provide. Facts like 'early dementia' gets missed & the hospital believe the resident when they give reasons for their condition. Other than that the confusion management has been good.

9.6.6 Strategies undertaken to resolve issues

In this section, the majority of respondents claim to have had no issues or problems with the way mentally confused residents were treated and cared for in hospitals. Of those who commented, quite a few shared some of the strategies

they have in place to assist processes associated with transfer of mentally ill and confused residents between hospitals and the aged care home.

Knowing of the risks, some aged care staff avoid hospitals wherever possible and set up alternative ways to access care or have someone present during the hospitalisation. The selection of comments below characterises many observations received on this issue:

> *The hospital do not have the staff or the facilities to cope with those with dementia, so we very seldom send them to the hospital and try to manage them here with the help of the Dr, who is very cooperative and will support us in any way to make this happen.*
>
> *Despite information being passed on to hospital staff re: assistance in managing confused residents as well as residents with communication difficulties, we are seeing residents who have been mismanaged from this regard, and it shouldn't need to be this way. Quite often, we would prefer to care for an acute resident in RACF if it means that their mental state is managed appropriately e.g. Dementia residents.*
>
> *Sufficient staff to manage confused resident not always available, hesitant to transfer resident with dementia unless family representative present.*
>
> *We often have to send an escort as hospital outpatient staff have no ability to manage. There are many times were our residents are sent home because they are too difficult for the hospital to manage. This means the resident has to be sent back again and again until the hospital provides the care/treatment required.*
>
> *Our residents all have an intellectual disability and most are unable to verbalise. Whilst residents are in hospital they are visited by staff members. When hospital staff have had difficulty managing our residents they have asked for some strategies etc which have assisted them.*

9.7 Summary and recommendations

On the issue of mental confusion and its management by hospital staff, half of the respondents have issues and half do not. Despite this division, the issues raised by those who do have experience of problems are quite disturbing to consider.

Essentially the major issue relates to perceptions of hospitals providing poor care such as routine use of physical and chemical restraint which strips residents of dignity and places them at greater risk of being neglected. The practice of sedating residents prior to transporting them in a relatively unsupervised situation to another place carries with it unwarranted risks to safety and general wellbeing.

The next area of concern is the practice observed by respondents of discrimination against aged care residents and older people with mental illness or confusion. It appears that hospital doctors and nurses and perhaps others do not have skills in differentiating between dementia, mental illness, grief, delirium or normal cognitive decline. As a result older people are denied a valid working diagnosis and presumed to have dementia when this may not be so. Respondents also imply that once an erroneous diagnosis of dementia has been applied to an older person, hospital staff allow it to influence all future interactions with that person. Yet still some will send confused residents away from their hospital, in taxis and with no clear destination in some instances.

The other major concern is the perceived mendacity of hospital staff who have developed a reputation among many of the respondents for mishandling the truth about residents and their condition or prognosis in order to clear hospital beds.

Consequently aged care respondents' confidence in the psychogeriatric and mental health skills of hospital staff is as low as the confidence held regarding their basic clinical and management skills.

9.7.1 Recommendations

Restore trust. The most effective way to ensure residents move safely between services is to build care partnerships based on honesty and integrity. Any clinician who breaches this basic tenet of ethical conduct needs to be reported to the professional registration authorities who will investigate and discipline as appropriate. For the remaining ethical staff, efforts need to be made for them to become familiar with each others' environments so that greater understanding becomes possible.

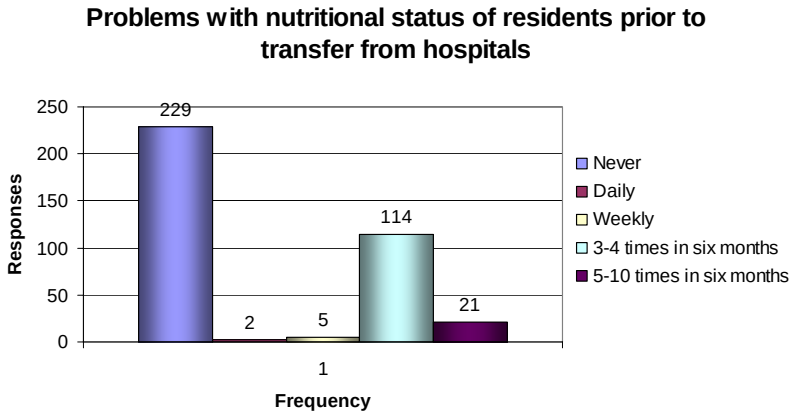
Update psychogeriatric skills of hospital staff. With the demographic changes well underway towards an older population it is unacceptable for hospital staff to focus attention only on younger patients and avoid the health challenges faced by older people. Aged care staff are the experts in this area and could be available to update hospital doctors and nurses in approaches to mental confusion and assessment of causes.

Consult and collaborate on care of mentally confused people. A process could be set up where hospital clinicians could access advice from aged care on issues arising in the hospital context. Consultants from aged care could, at cost recovery, be made available to coach hospital clinicians in assessment and management of mental confusion.

10 Nutritional status of residents on arrival at your facility

Residents returning from hospital stays are sometimes observed to be nutritionally disadvantaged. This situation can occur because of older persons' metabolism, or a health problem causing transfer to hospital for treatment, and also nutritional issues that may arise during the hospital stay.

The majority of respondents 61.7% (*n*=229) claim they have never observed nutritional problems with residents returning from hospitals. However, of those reporting experience of this issue, most say it happens frequently and a few claim it occurs every fortnight or so.



10.1 New South Wales

Respondents from NSW report that most (60% - 76%), regardless of location of aged care facility, have never had experience of residents returning from hospital in a nutritionally compromised state.

Of all the participating States, NSW accounts for one third of the total responses received in the category of nutritional problems which is less than each of the other States. Even so, the remaining residents reported by respondents as having problems in this area remain a cause for concern.

Of those in NSW reporting problems, most relate to large regional centres (40%) and country towns (36.36%). City centres report nutritional problems for 35.89% of their residents transferring from hospitals and the frequency of problems is quite high. Suburban areas report 23.34% having experienced residents returning from hospitals with nutritional problems.

NSW	***Frequency of resident nutritional status problems***					
Location of facility		3-4 times in six months	5-10 times in six months	Daily	Never	**Total**
A large metropolitan centre	Count	8	5	1	25	39
	% category	20.51	12.82	2.56	64.10	100.00
	% of Total	8.00	5.00	1.00	25.00	39.00
In a large regional centre	Count	8	0	0	12	20
	% category	40.00	0.00	0.00	60.00	100.00
	% of Total	8.00	0.00	0.00	12.00	20.00

In a small country town or village	Count	4	0	0	7	11
	% category	36.36	0.00	0.00	63.64	100.00
	% of Total	4.00	0.00	0.00	7.00	11.00
In the outer suburbs of a city	Count	5	2	0	23	30
	% category	16.67	6.67	0.00	76.67	100.00
	% of Total	5.00	2.00	0.00	23.00	30.00
Total	Count	25	7	1	67	100
	% category	25.00	7.00	1.00	67.00	100.00
	% of Total	25.00	7.00	1.00	67.00	100.00

10.2 Queensland

Overall Queensland respondents account for 45.35% of claims that residents have experienced nutritional problems while in hospital. The most frequently reported problems emerge from large metropolitan centres (52.63%) followed closely by large regional centres (51.85%). Outer suburban areas report a slightly lower incidence of nutritional problems (47.61%) however these seem to occur more frequently than in other locations.

QLD	***Frequency of resident nutritional status problems***					
Location of facility		3-4 times in six months	5-10 times in six months	Weekly	Never	**Total**
A large metropolitan centre	Count	9	1	0	9	19
	% category	47.37	5.26	0.00	47.37	100.00
	% of Total	10.47	1.16	0.00	10.47	22.09
In a large regional centre	Count	11	3	0	13	27
	% category	40.74	11.11	0.00	48.15	100.00
	% of Total	12.79	3.49	0.00	15.12	31.40
In a small country town or village	Count	5	0	0	14	19
	% category	26.32	0.00	0.00	73.68	100.00
	% of Total	5.81	0.00	0.00	16.28	22.09
In the outer suburbs of a city	Count	7	2	1	11	21
	% category	33.33	9.52	4.76	52.38	100.00
	% of Total	8.14	2.33	1.16	12.79	24.42
Total	Count	32	6	1	47	86
	% category	37.21	6.98	1.16	54.65	100.00
	% of Total	37.21	6.98	1.16	54.65	100.00

10.3 South Australia

In South Australia respondents from large regional centres and country towns report having no experience of problems related to resident nutrition while in hospitals. They did however report that facilities in large metropolitan areas (57.89%) experienced these issues and that they occurred frequently.
In suburban areas 40% report problems with resident nutritional status related to hospital stays.

SA		*Frequency of resident nutritional status problems*				
Location of facility		3-4 times in six months	5-10 times in six months	Weekly	Never	**Total**
A large metropolitan centre	Count	9	1	1	8	19
	% category	47.37	5.26	5.26	42.11	100.00
	% of Total	20.00	2.22	2.22	17.78	42.22
In a large regional centre	Count	0	0	0	8	8
	% category	0.00	0.00	0.00	100.00	100.00
	% of Total	0.00	0.00	0.00	17.78	17.78
In a small country town or village	Count	0	0	0	8	8
	% category	0.00	0.00	0.00	100.00	100.00
	% of Total	0.00	0.00	0.00	17.78	17.78
In the outer suburbs of a city	Count	3	1	0	6	10
	% category	30.00	10.00	0.00	60.00	100.00
	% of Total	6.67	2.22	0.00	13.33	22.22
Total	Count	12	2	1	30	45
	% category	26.67	4.44	2.22	66.67	100.00
	% of Total	26.67	4.44	2.22	66.67	100.00

10.4 Victoria and Tasmania

Respondents from Victoria and Tasmania (shown below) report that most have never experienced problems related to the nutritional status of residents treated in hospitals. Most issues were reported from facilities in large metropolitan (42.86%) and regional centres (33.34%).

VIC/TAS		*Frequency of resident nutritional status problems*					
Location of facility		3-4 times in six months	5-10 times in six months	Weekly	Daily	Never	**Total**
A large metropolitan centre	Count	12	3	0	0	20	35
	% category	34.29	8.57	0.00	0.00	57.14	100.00
	% of Total	12.24	3.06	0.00	0.00	20.41	35.71
In a large regional centre	Count	2	2	0	0	8	12
	% category	16.67	16.67	0.00	0.00	66.67	100.00
	% of Total	2.04	2.04	0.00	0.00	8.16	12.24
In a small country town or village	Count	6	0	1	1	17	25
	% category	24.00	0.00	4.00	4.00	68.00	100.00
	% of Total	6.12	0.00	1.02	1.02	17.35	25.51
In the outer suburbs of a city	Count	11	0	0	0	15	26
	% category	42.31	0.00	0.00	0.00	57.69	100.00
	% of Total	11.22	0.00	0.00	0.00	15.31	26.53

	Count	31	5	1	1	60	98
	% within category	31.63	5.10	1.02	1.02	61.22	100.00
Total	% of Total	31.63	5.10	1.02	1.02	61.22	100.00

10.5 Western Australia

Western Australian respondents were drawn mostly from metropolitan areas so naturally reports of issues will relate more to this group than to regional or country areas. In the large metropolitan areas 52.38% of respondents claim they have never experienced problems with residents' nutritional status. However remaining reports of problems account for almost a quarter of the total survey responses for this category.

WA	***Frequency of resident nutritional status problems***					
Location of facility		3-4 times in six months	5-10 times in six months	Weekly	Never	**Total**
A large metropolitan centre	Count	8	1	1	11	21
	% category	38.10	4.76	4.76	52.38	100.00
	% of Total	19.05	2.38	2.38	26.19	50.00
In a large regional centre	Count	3	0	0	6	9
	% category	33.33	0.00	0.00	66.67	100.00
	% of Total	7.14	0.00	0.00	14.29	21.43
In a small country town or village	Count	0	0	0	1	1
	% category	0.00	0.00	0.00	100.00	100.00
	% of Total	0.00	0.00	0.00	2.38	2.38
In the outer suburbs of a city	Count	3	0	1	7	11
	% category	27.27	0.00	9.09	63.64	100.00
	% of Total	7.14	0.00	2.38	16.67	26.19
Total	Count	14	1	2	25	42
	% category	33.33	2.38	4.76	59.52	100.00
	% of Total	33.33	2.38	4.76	59.52	100.00

10.6 Qualitative themes

Of all respondents, 113 (30.5%) provided voluntary comments and of these, 28 (25.78%) comment positively about their experiences with hospitals. By far the most common concern of respondents is that residents return with significant weight loss, especially if they have had a prolonged stay, for around a month, in hospital. The next most frequent type of comment relates to the information provided by hospitals about residents' nutritional status.

The comments are broadly themed as follows:

10.6.1 Reports by relatives about observed hospital practices

Relationships are built up over time between aged care staff and family members who frequently visit their relatives in the aged care home. In most instances this

relationships is one of trust and commitment to a shared goal of making residents as comfortable and happy as possible during the last part of their lives. Often relatives spend time in aged care homes and help with activities of daily life as and when they can. It is not surprising therefore that they tend to follow their loved one into hospitals if acute medical treatment is needed. While there they have an opportunity to observe the practices of hospital staff responsible for care and treatment of their relative.

> *Usually it is the relatives who state that trays are left by bed and staff do not assist or check if resident has eaten or needs help.*
>
> *Resident's relatives have stated that the resident would not at times be fed if not for the involvement of the family who would assist the resident in this function. Anecdotally, some relatives say that the have been to visit and will find the over-bed table with tray of food on it but nowhere near the resident. Staff have not checked to ensure the resident has been able to manage themselves or be fed.*
>
> *Many relatives tell us that if they don't attend at meal times the trays go back to the kitchen untouched. Acute staff do not feed the patients or give adequate fluids.*
>
> *Residents have been sent back after lunch or dinner yet they have not been fed. They state whilst in hospital not fed or given enough fluids. Staff do not open packs for them of cutlery, tops of juice etc. This is common feedback from families.*
>
> *Families report that they have not been assisted with feeding if unable to do so themselves-often have lost weight but this could be disease related as well.*
>
> *If residents have been in Outpatients, often return without adequate hydration, nutrition or toileting.*

Even residents report on the difficulty they experience in getting meals while in hospital:

> *The residents who can speak complain about hospital food. Those who cannot express their feelings do so through weight loss.*
>
> *At times resident waiting on transport does not have meal or hydration.*
>
> *High care residents who require assistance with meals sometimes don't get that assistance.*

Aged care staff frequently visit residents during their hospital stay and they too have observed problems faced by residents in accessing food and fluids in hospitals. The following selection of comments clearly shows the concerns of aged care staff on this issue:

> *Our concern for our residents is that if they are unable to feed themselves then we are not always confident that they are being feed their meals. On occasions staff have visited residents and see the meal tray there but no one feeding them.*
>
> *Loss of weight, not related to reason for admission. When staff visit resident in hospital - there appears to be a lack of physical assistance given to those who need.*
>
> *Residents lose weight in the acute care sector and not because of their illness, rather the staff do not ensure the resident's tray is near them or feed them if they require this.*
>
> *Often the nutritional status is poor; as acute staff do not have the time to hand feed patients.*
>
> *Residents are not fed as they can't feed themselves, meals taken away not eaten, no fluids etc.*
>
> *Residents that require physical assistance to eat do not always receive appropriate nutrition.*
>
> *Residents who are unable to feed themselves often miss out on their meals in hospital.*

10.6.2 Communication between hospital and aged care about nutritional status and needs

Difficulties relate to the lack of formal communication received about any assessments or reviews of residents' nutritional status or situation while in hospital. Some comments indicate efforts currently being made to communicate nutritional information however in some instances recommendations from hospital staff can be unrealistic:

> *Resident's nutritional status is always "fine". It may be useful to know if malnourished when admitted to hospital or if they have food issues.*
>
> *Problems when residents commence food supplements in hospital and then transferred back into Facilities, as many supplements are very, very expensive!*
>
> *Dietician expecting we can cook an individual meal for one resident. Commenting to relatives that the nursing home has let the resident dehydrate. Now the nursing home is being proactive by assessing that the residents fluid intake has decreased and is now dehydrated (Proactive Management) Not checking with the nursing home if we have the enteral feed in stock that the resident requires and expecting at 3pm on a Friday that we are able to get it. Then having to argue and plead our case so as the hospital supplies the feed until the Tuesday.*
>
> *Dietician does not always check what dietary fluids we provide and will prescribe the most expensive.*

Speech pathology services are greatly appreciated by most aged care staff, but again communication of assessment and therapy details could be improved upon:

> *Speech therapy reports are usually very good (detailed and helpful) - if they come back to us. Residents often come back with significant weight loss.*
>
> *It would be good if hospitals routinely provided the information. There have been three occasions in 6 months where a resident should have had a speech pathology review in the hospital but have been sent home without the review information and a recommendation that the home organise it.*
>
> *Resident not assessed by speech pathologist whilst in hospital. Sent back on inappropriate diet.*
>
> *Residents personal dietary choices not always met, and if need prompting or assistance with meals this does not always appear to occur. If there is a swallowing deficit, this area generally appears to be reasonably well addressed however, and communication prior to discharge regarding needs does often occur.*
>
> *At times there seems to be a disabling in the area of nutritional intake e.g. residents who may eat well with finger food or a soft diet, often return as a feed on a pureed diet, they are followed up by a speech pathologist who in turn is quite stunned to find that they are independently consuming a normal but modified diet.*
>
> *Multiple conversations with the speech therapists regarding dietary care often not required upon return to facility, or vice a versa.*

Short stays in hospital do not lead to measurable differences in body weight, however longer hospital stays do pose some risk because of the difficulties residents have in accessing supplies of, and appropriate types of food and fluids:

> *Residents that have come from short hospital stay state they are hungry but no decrease in nutritional status really.*
>
> *Constant reports from residents and families especially those with dementia and decreased vision - "No one tells them the meal is there or cuts it up for them". Weight loss is common.*

Might get whether needs assistance or whether soft/normal diet but very little on specifics i.e. aids required, what can do for themselves, likes/dislikes.

Sent home too early - had not received satisfactory oral intake before discharge. Weight loss. New swallowing problems diagnosed.

Not being fed in Accident/Emergency dept. (including diabetics and people on vitamised meals).

Not good re bowel care for long term.

Hospital will state that the resident is malnourished but no follow up.

10.6.3 Observed condition of residents upon return from hospital stay

Residents returning from a hospital stay are routinely re-assessed by aged care staff and many respondents commented on changes observed as a result of being in hospital. In most instances the critical issue is weight loss:

We now routinely weigh residents coming back from hospital because they have frequently lost excessive weight whilst away.

Residents suffer weight loss and dehydration after admissions in acute hospitals. Staff do not ensure they are offered drinks or assist them with the feeding of their meals. They are either too busy or just do not have insight into their daily needs.

It is disturbing to see some of our residents return from hospital with significant weight loss and looking like different people.

Nearly all residents returned from hospital including step down rehab etc have significant weight loss >3kg.

One resident returned to this facility after 10 days in hospital with a weight loss of 5 kilos.

Significant loss of weight - often more than 5kgs.

Weight loss is a feature of acute hospitalisation in the frail aged population. I can not give reasons why.

Significant weight loss in hospital, not followed up. Dietary intake not reviewed in hospital and swallowing issues not resolved while in hospital.

Residents who stayed in the hospital more than 30 days they came back with state of loss.

Weight loss is common.

Fluid intake is also a problem for some respondents and it seems that dehydration has been recognised by some hospital staff who then administer replacement fluids intravenously:

Residents have nearly always lost weight however they are often well hydrated as they have had a drip in.

Dehydration.

Clinically dehydrated - poor skin turgor - dry auxilla .

Efforts to compensate for compromised nutritional status can involve specially prepared meals, supplements and even epigastric feeding through nasal tubes. Quite apart from being frightening and uncomfortable, most of these treatments are expensive and require special skills to ensure safe management of treatment. While hospitals are in a position to initiate such treatments, access to supplies and equipment by the aged care home and families can be more difficult to arrange:

Resident has lost excessive amount of weight and is on a high calorie, very expensive replacement on admission when they are meant to be medically stable.

Residents often require additional nutritional drink supplements to assist with increase weight. As assessment as to a person's swallowing, etc., is not included in the profile received from the acute facility. Additional

> *information in relation to normal, soft and/or vitamised meals, including size of the meal, would be of assistance.*
>
> *Told they are on pureed diets which they are refusing and they are nutritionally compromised.*
>
> *Most residents return from hospital on a pureed diet? No review mechanism for this type of diet. The Proform drinks are not continued and weight loss occurs.*
>
> *This has not been a real problem lately but previously there seemed to be a trend of using PEG feeds to make it easier to fed difficult residents. There have been incidents where residents have not been assisted to eat while in hospital unless their family can do this.*
>
> *Resident with PEG not fed or given fluids for 18 hours, no explanation given.*
>
> *Sometimes inappropriate peg feeding regimes.*

Malnutrition and dehydration are very serious conditions for frail older people and if these occur in parallel with other serious medical conditions, the combination of problems can threaten survival. It is important therefore to understand the nature and extent of confounding nutritional conditions but some respondents report that hospital staff have accused them, without basis, of causing the problem:

> *We have residents on MST tool from Abbott for all admissions. The problem I have is that the hospital continually "accuses" the nursing home of residents being dehydrated which in fact is not always correct. We do admit specifically on occasion for clients with hydration issues related to their physical/mental status.*
>
> *Little information is given in regard to this area but when we transfer a resident to the acute sector the doctors invariably advise the family that the resident is malnourished and dehydrated without ever reviewing with the facility the dietary and fluid regimes put in place during the residents time in a facility.*

Although some aged care respondents admit that causes of malnutrition and dehydration could include a more complex array of factors:

> *Often deconditioned - may be long standing - not just hospitalization.*
>
> *This is also rare it is usually the residents' medical condition and failing health that is the main contributor to poor nutrition.*
>
> *Some residents have incidences of weight loss, also may be due to their medical condition and environmental factors.*

10.6.4 Strategies to ensure good nutrition

Staff in aged care homes appear to have recognised risks associated with hospital stays and nutritional status, and have devised a range of strategies to obviate these risks to a certain extent. One recommendation is to avoid sending residents to hospital if at all possible:

> *Most residents lose weight in hospital and that is one of the reasons we avoid sending them there.*

Other strategies involve efforts to restore the resident's condition once they have arrived back to the aged care home:

> *Resident's often lose a lot of weight when admitted to hospital then on return the family become concerned and it is then our job to try and get their weight back to an acceptable level. This costs us in staff time managing the food for the resident, and coordinating with the family as well as the obvious financial costs with food and extra nutritional products.*
>
> *Residents who are at risk of weight loss follow a special nutritional supplement diet at our facility. When they are in hospital it is not followed*

due to the cost involved and this presents a problem when they return to the facility.

Once in our facility with appropriate diet and assistance/supervision residents gain weight. Cognitive/physical abilities improve.

Some respondents report that dietician reports have also assisted them to provide better nutritional care following discharge:

Often assessed by dietician. The resident may not be happy with the recommendations ice thickened fluids pureed meal.

Always returned with Dietician report if nutrition is a problem.

Overall excellent, dietetics personnel have done good plans and these have been relayed to us.

10.6.5 Not a problem

Of the many respondents who report no difficulties with nutritional status of residents following a hospital stay, some provided comments about that experience and it seems that hospitals with effective dietetics and speech therapy services are in a position to provide appropriate care for older patients:

Currently we have not had any concerns over the nutritional status of residents returning from hospital.

Our facility has not experienced problems in regard to this issue.

They are often well fed and nutrition requirements abided by.

Very rare as we have a local proactive dietician with referral of inpatients occurring.

Generally not a problem. Biggest question is when were bowels last opened especially when resident is on aperients.

Dietetics and Speech Therapists are generally very good at faxing information for a transferring resident.

Not an issue, although there is not a lot of communication.

The local hospital has an active and well resourced dietetics service which monitors the nutritional status of inpatients.

10.7 Summary and recommendations

Of all the problem categories examined in this report, nutritional status issues affect less than 40% of respondents although problems when they occur are spread across all locations. In fact 25% of comments received are quite positive about the way hospitals manage nutrition for older people in their care. In NSW particularly hospitals are undertaking focused strategies to improve the way nutritional status is assessed and problems addressed.

The issues that are reported by respondents mostly involve severe weight loss by residents who go to hospital and this is especially so the longer the hospital stay. In these instances the causes of weight loss can include difficulty in getting food and drinks in the hospital environment; inappropriate food and food preparation and no feeding assistance for people with disability; no monitoring of food eaten or left by patients and the full plate is removed at the end of mealtime.

Some respondents commented on the information provided to them about diet and nutrition arising from hospital dietician or speech pathologist assessments which can sometimes be inadequate. In other instances some of the recommendations in these reports are somewhat unrealistic and quite expensive for families to purchase.

The issue of hospital staff competence was again raised under this problem category with respondents detecting a lack of interest by hospital staff in secondary conditions such as diabetes or dehydration and when a crisis point is

reached, the remedy is intravenous replacement rather than ongoing assistance to drink fluids and prevent dehydration. The unethical behaviour of some hospital staff was also commented upon in terms of some clinicians telling families that aged care homes have caused the malnutrition and dehydration which developed during the hospital stay.

10.7.1 Recommendations

Improve communication. Assessments and reports conducted by dieticians and speech pathologists need to be shared with aged care homes. Some avenue is needed to allow follow-up communication and consultation with hospital based specialists as aged care planning gets underway. Where unethical behaviour is known to have occurred, aged care staff need to be able to lodge a formal complaint with the hospital as well as the professional registration authorities.

Evaluate basic nursing skills of hospital staff and update as necessary. Whether older people are being neglected because nurses are so busy or because they do not regard basic nursing tasks as part of their role, the consequences for older people can be measured in misery. Staff skill deficiencies need to be assessed and inservice provided as needed.

Trial the introduction of qualified care staff in hospital environments. If nurses are too busy to undertake basic care, their team could be augmented with qualified care staff as occurs successfully in aged care and other environments.

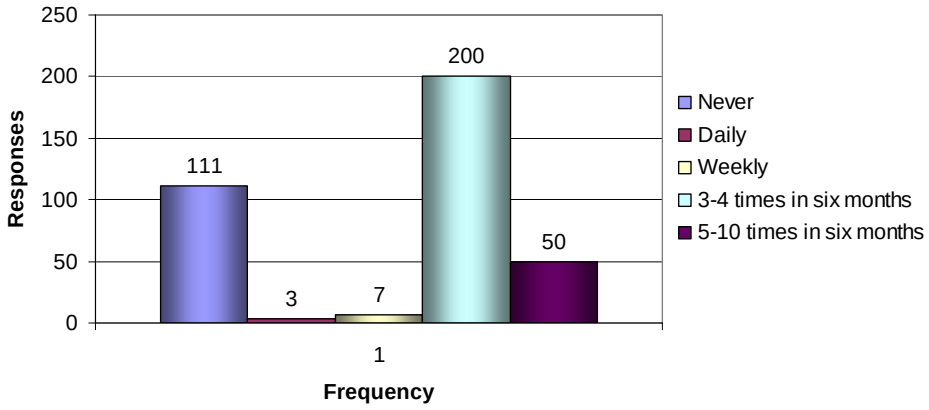
11 Skin integrity status of residents on arrival at your facility

For many residents who transfer to hospital for a few days, the issue of skin care relates to prevention of injury (such as skin tears, bruises and puncture wounds) and also for pressure-caused necrosis developing because of prolonged immobility or resting bony prominences on hard surfaces.

Further compromise to skin integrity arises from neglected moistness or abrasive, irritating materials attached to frail skin as well as bruises caused by poor manual handling or being bumped with equipment. Further skin integrity issues can arise from prolonged chemical and physical restraint.

The graph shown below indicates the frequency of issues with skin integrity upon residents' return from hospital stays. Of all respondents, 70% (n=260) report experience of skin problems suffered by residents returning from hospital.

Problems with skin integrity status of residents prior to transfer from hospitals



11.1 New South Wales

73% of respondents from NSW claim to have personal knowledge of skin integrity issues associated with residents transferring from hospital services. Respondents from aged care facilities located in outer suburbs appear to have fewer problems with 36.67% (just over one third) able to say they have never experienced residents having skin problems as a result of hospital care and treatment.

NSW	***Frequency of resident skin integrity problems***						
Location of facility		3-4 times in six months	5-10 times in six months	Weekly	Daily	Never	**Total**
A large metropolitan centre	Count	19	10	0	1	9	39
	% category	48.72	25.64	0.00	2.56	23.08	100.00
	% of Total	19.00	10.00	0.00	1.00	9.00	39.00
In a large regional centre	Count	13	2	1	0	4	20
	% category	65.00	10.00	5.00	0.00	20.00	100.00
	% of Total	13.00	2.00	1.00	0.00	4.00	20.00

In a small country town or village	Count	6	2	0	0	3	11
	% category	54.55	18.18	0.00	0.00	27.27	100.00
	% of Total	6.00	2.00	0.00	0.00	3.00	11.00
In the outer suburbs of a city	Count	14	5	0	0	11	30
	% category	46.67	16.67	0.00	0.00	36.67	100.00
	% of Total	14.00	5.00	0.00	0.00	11.00	30.00
Total	Count	52	19	1	1	27	100
	% category	52.00	19.00	1.00	1.00	27.00	100.00
	% of Total	52.00	19.00	1.00	1.00	27.00	100.00

11.2 Queensland

In Queensland respondents claiming never to have seen skin integrity problems arising from residents' hospital stays is 24.42% (just under a quarter). Variation across locations can be seen in the table below with the largest proportion being small towns (84.21%) followed closely by large regional centres (81.48%). Of the higher population density areas, suburban areas report problems from 61.9% of respondents and 73.68% of large metropolitan centre respondents.

QLD	***Frequency of resident skin integrity problems***						
Location of facility		3-4 times in six months	5-10 times in six months	Weekly	Daily	Never	**Total**
A large metropolitan centre	Count	12	1	0	1	5	19
	% category	63.16	5.26	0.00	5.26	26.32	100.00
	% of Total	13.95	1.16	0.00	1.16	5.81	22.09
In a large regional centre	Count	17	5	0	0	5	27
	% category	62.96	18.52	0.00	0.00	18.52	100.00
	% of Total	19.77	5.81	0.00	0.00	5.81	31.40
In a small country town or village	Count	14	2	0	0	3	19
	% category	73.68	10.53	0.00	0.00	15.79	100.00
	% of Total	16.28	2.33	0.00	0.00	3.49	22.09
In the outer suburbs of a city	Count	9	3	1	0	8	21
	% category	42.86	14.29	4.76	0.00	38.10	100.00
	% of Total	10.47	3.49	1.16	0.00	9.30	24.42
Total	Count	52	11	1	1	21	86
	% category	60.47	12.79	1.16	1.16	24.42	100.00
	% of Total	60.47	12.79	1.16	1.16	24.42	100.00

11.3 South Australia

The picture from South Australia is somewhat more positive with 33.33% of respondents claiming never to have had experience of skin integrity problems with residents transferring from hospitals. Most responses within this category are drawn from the large metropolitan centres where 73.68% of respondents in this category claim to have seen such problems.

When comments received from respondents across Australia are taken into consideration along with respondent data, a better idea can be gained of the misery and loss of functional capacity of residents who suffer these setbacks.

SA		*Frequency of resident skin integrity problems*				
Location of facility		3-4 times in six months	5-10 times in six months	Weekly	Never	**Total**
A large metropolitan centre	Count	11	3	0	5	19
	% category	57.89	15.79	0.00	26.32	100.00
	% of Total	24.44	6.67	0.00	11.11	42.22
In a large regional centre	Count	2	2	0	4	8
	% category	25.00	25.00	0.00	50.00	100.00
	% of Total	4.44	4.44	0.00	8.89	17.78
In a small country town or village	Count	3	1	0	4	8
	% category	37.50	12.50	0.00	50.00	100.00
	% of Total	6.67	2.22	0.00	8.89	17.78
In the outer suburbs of a city	Count	4	3	1	2	10
	% category	40.00	30.00	10.00	20.00	100.00
	% of Total	8.89	6.67	2.22	4.44	22.22
Total	Count	20	9	1	15	45
	% category	44.44	20.00	2.22	33.33	100.00
	% of Total	44.44	20.00	2.22	33.33	100.00

11.4 Victoria and Tasmania

Similar to the above pattern for South Australia, Victorian and Tasmanian reports of experience of residents returning from hospital with compromised skin integrity are similar with 33.67% able to say they have never seen this occur. The distribution of problems seen by respondents indicates that most have involved large metropolitan areas with 77.14% of respondents indicating knowledge of such problems occurring on a fairly frequent basis. The next largest group are from suburban areas with 69.23% reporting problems with residents' skin integrity on return from hospital.

VIC/TAS		*Frequency of resident skin integrity problems*					
Location of facility		3-4 times in six months	5-10 times in six months	Weekly	Daily	Never	**Total**
A large metropolitan centre	Count	23	2	2	0	8	35
	% category	65.71	5.71	5.71	0.00	22.86	100.00
	% of Total	23.47	2.04	2.04	0.00	8.16	35.71
In a large regional centre	Count	6	2	0	0	4	12
	% category	50.00	16.67	0.00	0.00	33.33	100.00
	% of Total	6.12	2.04	0.00	0.00	4.08	12.24

In a small country town or village	Count	10	1	0	1	13	25
	% category	40.00	4.00	0.00	4.00	52.00	100.00
	% of Total	10.20	1.02	0.00	1.02	13.27	25.51
In the outer suburbs of a city	Count	16	2	0	0	8	26
	% category	61.54	7.69	0.00	0.00	30.77	100.00
	% of Total	16.33	2.04	0.00	0.00	8.16	26.53
Total	Count	55	7	2	1	33	98
	% category	56.12	7.14	2.04	1.02	33.67	100.00
	% of Total	56.12	7.14	2.04	1.02	33.67	100.00

11.5 Western Australia

The Western Australia group, mainly from metropolitan areas, has a proportionately better result to report than other States. 42.86% of respondents from this location say they have never experienced problems with residents' skin on return from hospitals. However 57.14% who did, indicate that such events occurred relatively frequently. Results for regional and suburban areas are similar but with such low response numbers it is difficult to extrapolate.

WA	***Frequency of resident skin integrity problems***					
Location of facility		3-4 times in six months	5-10 times in six months	Weekly	Never	**Total**
A large metropolitan centre	Count	9	2	1	9	21
	% category	42.86	9.52	4.76	42.86	100.00
	% of Total	21.43	4.76	2.38	21.43	50.00
In a large regional centre	Count	6	1	0	2	9
	% category	66.67	11.11	0.00	22.22	100.00
	% of Total	14.29	2.38	0.00	4.76	21.43
In a small country town or village	Count	0	0	0	1	1
	% category	0.00	0.00	0.00	100.00	100.00
	% of Total	0.00	0.00	0.00	2.38	2.38
In the outer suburbs of a city	Count	6	1	1	3	11
	% category	54.55	9.09	9.09	27.27	100.00
	% of Total	14.29	2.38	2.38	7.14	26.19
Total	Count	21	4	2	15	42
	% category	50.00	9.52	4.76	35.71	100.00
	% of Total	50.00	9.52	4.76	35.71	100.00

11.6 Qualitative themes

Of the total respondents, 48% (n=179) volunteered comments on residents' skin integrity status upon return to the RACF. Only 3.3% (n=6) of those who provided comments said they are unaware of any problems arising from hospital care of residents' skin. A selection of themed comments is provided below:

11.6.1 Observations of skin breakdown noted on residents' return from hospital

Of all the themes related to skin integrity status, this selection of comments was one that attracted most attention (73 separate entries). The likelihood of frail older residents developing skin ulcers and other wounds as a result of a hospital stay is well known to respondents:

> *Most residents come back with a pressure ulcer - sacrum or heels after extended >2 weeks stay in hospital.*
>
> *Dependant on the length of stay 50% of residents would come back with some skin impairment relating to pressure.*
>
> *Multiple long stay residents in hospital return with pressure areas of sacrum and heels.*
>
> *Long term stay usually results in a breakdown in skin integrity.*
>
> *Residents sometimes come into nursing homes from hospitals with shocking decubitus pressure sores.*
>
> *Residents return or come from acute settings with pressure areas on sacrum and heels. In this time period no pressure areas have developed on residents while in aged care facility.*
>
> *Many residents return from hospital with pressure areas on their sacrum/heels, and similarly to the issue around weight loss, it then becomes our responsibility to fix problems created by acute care facilities. The same HR, PR and financial issues that are seen in nutritional status changes are also seen in this area.*
>
> *Residents have returned from major teaching hospitals with pressure area wounds.*
>
> *Again most cases return with skin injury not present on transfer from us. The heels, buttocks and groins are danger areas indicating issues of turning and pressure area care.*

Some respondents comment that it is not just residents returning from acute hospitals who have skin problems they include new residents as well. They also comment on related issues such as hygiene and general status:

> *Skin integrity is usually impaired when residents arrive home from hospital or on admission to an aged care facility. Conditions can vary from mild impairment or to gross impairment relative to time spent in hospital or in some cases from time spent at home prior to admission to hospital.*
>
> *Skin tears and pressure ulcers are frequently present on skin of returning residents and on new residents.*
>
> *The resident general comes back unkempt, fingernails are long etc and with a break down in skin.*
>
> *Residents have returned with bruising and skin tears following falls while in hospital.*
>
> *Resident in hospital for 5 days - no ADLs attended to. No pressure care used. Returned with pressure sores x2.*
>
> *Elderly residents sent to acute wards have often returned filthy with poor skin integrity after lengthy stays.*
>
> *Skin is usually dry, hydration poor.*
>
> *Returned to home with stage 4 pressure areas. Returned in state of poor hygiene.*
>
> *Skin tears, lumps, bumps, missing digits etc.*

One distressing aspect of this situation for aged care staff is the realisation that residents invariably did not have compromised skin integrity prior to their admission to hospital, but when they return they do so with ulcers, skin tears and reddened areas that could quickly become necrotic:

We have received residents back from hospital who when they were admitted had no pressure areas and have come back to us with pressure areas.

Residents who have been sent to hospital from facility without any problems with skin integrity have returned with pressure ulcers.

Returning with pressure areas is one area of concern, especially when they were not admitted with them.

Residents returned from hospital on 2 occasions with stage 2 pressure sores 1 occasion with stage 1 pressure area when these did not exist prior to transfer.

Have multiple instances of residents returning from acute hospitals with pressure areas that were not existing previously.

Residents returning with impaired skin integrity when skin intact when residents had left the aged care facility.

Residents sent to hospital with intact skin integrity have returned with pressure sores.

Very common to receive residents with pressure sores and also residents we transfer out with no skin problems come back with skin breakdown.

Occasionally resident who was previously independently mobile will return with pressure area on heels.

Bruising and skin tears have also been commented upon by several of the respondents, along with other skin integrity problems. Bruising and skin wounds are usually caused to frail older people who have been bumped by equipment or as a result of people assisting them to move or transfer but without taking the extra care and time needed to safeguard frail skin and muscle:

Returned with bruising, skin tears and pressure areas.

Pressure areas, bruises and skin tears on return.

Lots of pressure areas on return from hosp, & bruises & skin tears.

Skin tears and bruising.

Have had several residents sent with pressure areas, ulcers, skin tears and bruising.

Often no discharge appears, yet we find skin tears, wounds etc that have been dressed.

Despite these wounds causing pain and risks of hospital acquired infections, there seems to be an attitude of neglect among some hospital staff in relation to preventing trauma or admitting what has occurred and attempting to treat the wounds and pain – or even to make honest reference to them in discharge documentation for the sake of residents' welfare:

Residents with pressure sores, reddened areas and no associated documentation as to what has been done or how sores occurred.

This is an ongoing problem as the acute hospitals do not provide suitable mattresses for frail patients.

Residents often arriving with skin tears, wounds and pressure ulcers at various stages. Usually notified of wounds but often not told of skin tears and pressure ulcers unless already stage 3 or 4.

Just once there was a pressure area that had developed during hospital stay that probably could have been cleared up a little more before coming to us.

Many of the residents develop pressure ulcer/s while in hospital. The description of the pressure ulcer/s is not always appropriate and does not accurately reflect the ulcer/s.

11.6.2 Explanations of causes of skin breakdown

Because so little information is provided by hospital staff about how frail older people have sustained wounds and bruises while in hospital, many respondents

(37 separate comments) were moved to speculate on how these could have occurred. Some believe that the hospital environment itself could be a cause:

> *The longer that our frail elderly residents with poor mobility are in hospital the more likely it is that they will return with skin breakdown related to pressure on heels, ears, and particularly sacrum.*
>
> *Hospitals are best suited to the independent mobile person not elders who can be left for long periods without repositioning, there seems to be a gap in the desire of some hospital nurses to comprehend that elders are at risk of pressure areas if not repositioned, adequately nourished and hydrated. Once there is a problem then referral occurs but prevention is what is needed.*
>
> *Each resident we have sent in to hospital for more than one week: returns with a pressure area. We have had discussions at the hospital about this. Our only pressure areas arise from hospital stays.*

Others believe that hospital staff no longer take adequate steps to prevent skin breakdown in older patients:

> *Hospitals are bad at managing skin!*
>
> *It used to be that patients coming from aged care had pressure sores. Now it is the reverse. We have to completely check our residents' skin integrity when they return from the acute care sector as they are extremely prone to decubitus ulcer formation while in the acute care environment....??? Where is the old fashioned (possibly) pressure area care? ....gone!*
>
> *Skin Tears and pressure area sores not documented and sometimes not even a dressing on sloughy - oozing pressure sores. Very dry skin - relatives constantly comment that in hospital the nurses do not apply Sorbelene cream etc.*

Some respondents have noted the emergence of 'blaming' by hospital staff in an attempt to shift responsibility for skin breakdown in older patients admitted from aged care facilities:

> *Frequently our facility is blamed for being the causers of pressure areas despite residents going to hospital with skin intact.*
>
> *Pressure areas on return from hospital admission, yet prior no break down in skin integrity*
>
> *On several occasions residents return from hospital with pressure areas (particularly toes and heels) only if an inpatient for an extended time. However the hospital generally states that they must have developed while at the AC home.*
>
> *Skin tears or wounds not documented on transfer to facility or remarks made to relatives that resident has wound on arrival to wards of hospital. In fact resident's skin was intact prior to transfer.*
>
> *Prior to transfer to hospital and upon return we photograph residents' skin and any skin integrity impairment; this has been necessitated by the residents' relatives who have stated that the hospital said we transferred their relative with a decubitus ulcer.*
>
> *We frequently inherit serious problems relating to skin integrity. We have photographic evidence of this.*

Respondents have in turn questioned the professional practices of hospital staff in terms of basic nursing care provided to older people in their care, and then not being honest and mentioning skin breakdown when it develops:

> *This is our biggest problem. Skin breakdown in the elderly can occur within a few days of transfer to hospital and unless staff are vigilant our residents often return with pressure or trauma related skin breakdown*
>
> *Often heels and buttocks broken down, obviously not turned in bed. Mostly have IDC to save hospital staff having to walk resident to toilets.*

Residents returned with skin breakdown due to inadequate pressure area care and wounds inappropriately managed and inappropriate bruises due to incorrect manual handling

This is something that is experienced often with residents being admitted after long term stays in acute care and when admitting from the RACF and allowed to spend their stay on trolleys waiting to be assessed.

Bruising often noted, pressure ulcers to heels following orthopaedic surgery or extended time in bed. Very dry skin, in particular elbows - is there pressure care and moisturising of skin ???

Residents frequently return with skin tears which have been treated inappropriately, resulting in long term dressings because of skin loss or ulcerations.

2 Residents transferred back to the N/H following several days in acute care with broken areas on their sacrum. 1 Resident returned with severe excoriation around the PEG site which was not evident when he was transferred.

From experience, if the resident stays in hosp. longer than a couple of weeks, and has dementia, bed sores are likely.

This is usually related to pressure areas or to skin tears that have occurred when they have fallen and hospital staff have 'forgotten' to mention them.

Residents sustaining injuries in hospital, e.g. skin tears and pressure ulcers is common, and information on discharge is absent or not complete. The ordering of expensive dressings which are not able to be supplied by facility or afforded by resident makes reassessment of wounds necessary.

Skin integrity is usually ok and residents well looked after. However I have noticed that clients transferred from hospitals for permanent care especially at our facility have been lacking consultation from a podiatrist. One resident was admitted with toenails which he was walking on after spending months at [hospital] awaiting appropriate care placement.

The issue of hospital staff failing to acknowledge skin breakdown becomes even more critical when resistant strains of bacterial infections are involved. By neglecting to provide details of these dangerous infections prior to discharging people back to an aged care environment, the referring staff place other residents, their families and aged care workers at unnecessary risk:

Residents have returned with new pressure areas or with MRSA infections in wounds that had not grown this bacterium prior to transfer.

Resident returned from hospital with hospital acquired MRSA. Residents returning with infected pressure area.

This is an ongoing issue, often compromised by the development of resistant bacteria in wounds.

11.6.3 Communication on resident care and treatment

Acute hospitals are set up to deal with medical problems and it is not unexpected that the medical cause of admissions to hospital becomes the primary focus of their interest and interventions. Older people though, require a more comprehensive approach to health issues because of many well known and widely acknowledged interactions that can occur when one aspect of an older person's health status is compromised. The result can resemble a 'cascade' effect where other body systems and organs become involved in a physiological response triggered by the original problem.

Aged care staff understand the concept of holistic care and treatment and are alert to any signs that some aspect of the person's health is at risk. Unfortunately, when residents return from a hospital stay details of care and treatment given in hospital are not always provided to them. Care planning and continuity of care is difficult to set up without information from hospital clinicians. Considerable expenditure of effort and time is often needed for RACF staff to seek and retrieve pertinent information from hospitals about the hospital stay. In some locations

hospitals are developing a reputation in relation to their approach to care of older people and their lack of understanding of aged care services:

> *We inherit pressure areas from time to time. Some hospitals known to be more likely to send residents to return with pressure areas / decubitus ulcers.*
>
> *The development or the exacerbation of pressure areas while in the local hospital, the usual lack of documentation related to the current wound care management, the lack of documentation in relation to some wounds e.g. no documentation about some pressure areas or skin tears although not new.*
>
> *Lack of documentation r/t pressure areas. Pressure areas present and seemingly viewed by this hospital as acceptable part of post # nof progress.*
>
> *Residents have returned to facility with pressure areas and broken areas on heels, hips and buttocks which are not documented on the transfer form and denied by hospital staff when telephoned re same.*
>
> *Limited understanding at the local hospital in relation to the financial constraints experienced when providing wound care in the facility.*

Skin breakdown is often not reported as part of a returning resident's condition, as well as any treatment given while in hospital. Respondents report discovering wounds, ulcers and bruises when they assist residents to shower following their return home:

> *Skin integrity is rarely provided in discharge notes from hospitals. Unless there is a complex wound present skin tears and ulcers are usually found when the resident is undressed for bed or showered in the morning after their arrival.*
>
> *Pressure areas developed on sacrum and or heels no prior notice until resident is back in the facility.*
>
> *Skin integrity is not always accurately recorded, have found pressure ulcers on residents that we had not been made aware of.*
>
> *Skin integrity is a large problem on receiving residents back following an acute episode in hospital. On verbal/written information given, seems to underplay the extent of the skin breakdown, quite often resulting in intense management and expense.*
>
> *Have previously had problems with pressure sores present on return from hospital when there were none on admission, and this was not disclosed during discharge planning.*
>
> *Inappropriate skin assessment ratings given. Pressure sores or blisters present. Bruises that have not been identified on discharge documentation.*
>
> *Many of the residents develop pressure ulcer/s while in hospital. The description of the pressure ulcer/s is not always appropriate and does not accurately reflect the ulcer/s.*
>
> *Transfer forms often do not indicate that there is a wound requiring dressing, or they are returned without any dressing at all. (? transfer arranged too quickly for staff to complete necessary care).*
>
> *Large pressure areas on return to facility, not documented, no information about how long pressure area has been and if healing or increasing.*
>
> *NO information is providing in relation to skin integrity. If the resident has suffered a skin tear or wound while in hospital there is usually no reference made to this.*

Staff in both high and low care facilities are frequently required to compensate for the lack of information and treatment details related to unacknowledged skin breakdown and bruises suffered by residents during their hospital stay. For some this poses a significant hurdle to be overcome in the interests of residents returned to their care:

Resident having pressure areas when they return to us. Not adequate clinical support to assist RACF staff to manage complex wound care.

Residents returning to the facility with bed sores and no medical equipment backup. Dehydration and resident being placed on nutritional drinks that we don't supply because they are too expensive.

Often have wounds not treated with up to date wound care products, or not noticed at all, pressure areas.

Lack of information, no care plan sent to facility.

The resident arrives with skin breakdown that is not mentioned anywhere in the discharge summary.

11.6.4 Strategies and suggestions

Of the comments received in relation to skin integrity issues, a small number of respondents suggested strategies to improve the situation. Partnerships in care efforts seem to be beneficial:

The one resident we had returned had a wound which needed complex dressings. We were provided with all the information we needed, plus follow up support.

We provide preventative measures pre-transfer. All post-op admissions in 6 months have had wounds related to poor management.

Pressure sores from hospital are common and we heal them one to two weeks after readmission

It could be better managed if the acute care sector had better resources.

Our residents have returned with pressure areas that have been costly in both financial and comfort terms. We have been doing some calculations as to the cost of repairing inherited problems to highlight this issue to hospital staff.

11.7 Summary and recommendations

Of all the clinical care issues contained in the problem categories surveyed, compromised skin integrity is the most widespread and a very disturbing issue. Reports of residents who were previously without skin problems, returning from a hospital stay with skin tears, decubitus ulcers on sacrum, heels and other bony prominences, and bruising from rough handling and other causes, are distressing to consider. Each of these people experiences pain and disfigurement arising from their wounds, as well as their emotional response to being treated in such a manner and not being able to protect themselves or take care of their own hygiene or wound care needs.

Iatrogenic trauma and nosocomial illnesses are well known to hospitals and the evidence provided through this survey strongly supports the inclusion of skin breakdown as a result of the hospital environment, and trauma related to manual handling and other interventions, as measurable items under the International Classification of Diseases in hospital legal documentation.

Currently there seems to be no acknowledgement of these issues in clinical notes and respondents see few attempts by hospital staff at preventing trauma or even treating wounds when they occur. There is no hospital acknowledgement of these wounds and bruises when residents return to aged care. In fact, respondents perceive an attitude of mendacity and blame emanating from the hospitals they encounter where some clinicians falsely accuse aged care homes of causing the wounds and even mislead families into blaming the aged care home. The reputation of some hospital clinicians is such that respondents have taken to photographing residents' skin prior to transferring them to hospital and again on their return in order to prove to families that care given prior to hospital admission was safe, effective and of high quality.

11.7.1 Recommendations

Work with hospitals to improve quality and safety for older patients. Aged care providers need to be able to feed into the quality and safety effort that should be occurring in hospitals so that unsafe and unethical behaviour of hospital clinicians can be reported and dealt with appropriately.

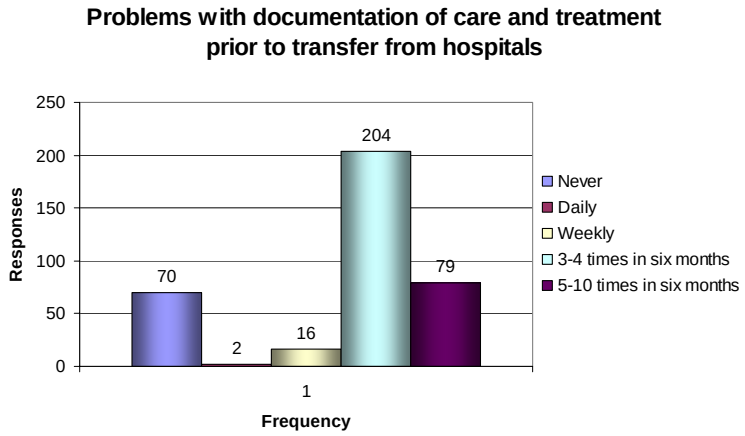
Cost recovery for iatrogenic and nosocomial problems transferred to aged care and families should be invoiced back to the hospital responsible for wounds, infections and mental distress caused to residents during hospital stays.

Introduce qualified care staff to work with hospital clinicians. Care staff could focus on the general needs of older patients and reduce damage that can arise from neglect.

12 Documentation related to medical and nursing treatment prior to transfer to facility

Previous questions relate to timing of transfers and efforts to coordinate transport and other aspects of resident transfers from hospitals however, issues about documentation containing essential details of hospital treatment were raised because quality of professional communication affects all aspects of ongoing care and management.

Assessment, care and treatment documentation is the basis upon which multi-disciplinary teams ensure the patient or resident receives services that are congruent with assessments. In this way continuity of care and treatment approaches can be maintained across different services. The graph below shows that 81% (n=301) of respondents had some experience of problems with treatment and care documentation provided by hospitals for residents returning to aged care.



12.1 New South Wales

Respondents in NSW report varying levels of satisfaction with the amount and quality of documentation received from hospitals following residents' acute care episode. Overall only 23% of NSW respondents were able to say they have never had such problems however those from country towns seem to have more problems than other areas with 81.82% of people from such locations claiming to have problems with hospital documentation of medical and nursing interventions.

NSW	***Frequency of care and treatment documentation problems***						
Location of facility		3-4 times in six months	5-10 times in six months	Weekly	Daily	Never	**Total**
A large metropolitan centre	Count	17	11	0	1	10	39
	% category	43.59	28.21	0.00	2.56	25.64	100.00
	% of Total	17.00	11.00	0.00	1.00	10.00	39.00
In a large regional centre	Count	11	3	1	0	5	20
	% category	55.00	15.00	5.00	0.00	25.00	100.00
	% of Total	11.00	3.00	1.00	0.00	5.00	20.00

In a small country town or village	Count	9	0	0	0	2	11
	% category	81.82	0.00	0.00	0.00	18.18	100.00
	% of Total	9.00	0.00	0.00	0.00	2.00	11.00
In the outer suburbs of a city	Count	16	8	0	0	6	30
	% category	53.33	26.67	0.00	0.00	20.00	100.00
	% of Total	16.00	8.00	0.00	0.00	6.00	30.00
Total	Count	53	22	1	1	23	100
	% category	53.00	22.00	1.00	1.00	23.00	100.00
	% of Total	53.00	22.00	1.00	1.00	23.00	100.00

Outer suburban respondents from NSW were close behind at 80%. Large metropolitan (74.36%) and regional areas (75%) seem to have similar levels of difficulty in accessing adequate hospital documentation of what occurred with residents during their hospital stays.

12.2 Queensland

The situation in Queensland shown below appears much more critical than in NSW when considered proportionately. Very few respondents were in a position to say they had never had experiences of inadequate hospital documentation about what occurred with residents during their hospital stays. In relation to responses from each locality, the highest proportion of problems occur in large regional centres (92.59%) and outer suburbs (90.48%). The rate for metropolitan centres and country towns is quite similar overall but problems with documentation occur more frequently in central city areas.

QLD	***Frequency of care and treatment documentation problems***					
Location of facility		3-4 times in six months	5-10 times in six months	Weekly	Never	**Total**
A large metropolitan centre	Count	7	7	2	3	19
	% category	36.84	36.84	10.53	15.79	100.00
	% of Total	8.14	8.14	2.33	3.49	22.09
In a large regional centre	Count	13	10	2	2	27
	% category	48.15	37.04	7.41	7.41	100.00
	% of Total	15.12	11.63	2.33	2.33	31.40
In a small country town or village	Count	8	8	0	3	19
	% category	42.11	42.11	0.00	15.79	100.00
	% of Total	9.30	9.30	0.00	3.49	22.09
In the outer suburbs of a city	Count	9	7	3	2	21
	% category	42.86	33.33	14.29	9.52	100.00
	% of Total	10.47	8.14	3.49	2.33	24.42
Total	Count	37	32	7	10	86
	% category	43.02	37.21	8.14	11.63	100.00
	% of Total	43.02	37.21	8.14	11.63	100.00

12.3 South Australia

In South Australia a larger proportion of respondents claim they had never experienced problems with documentation but even so, 78.95% of those from large metropolitan centres do report such experiences. Similar levels of problems are reported from the other three location categories.

SA	*Frequency of care and treatment documentation problems*					
Location of facility		3-4 times in six months	5-10 times in six months	Weekly	Never	**Total**
A large metropolitan centre	Count	12	3	0	4	19
	% category	63.16	15.79	0.00	21.05	100.00
	% of Total	26.67	6.67	0.00	8.89	42.22
In a large regional centre	Count	3	3	0	2	8
	% category	37.50	37.50	0.00	25.00	100.00
	% of Total	6.67	6.67	0.00	4.44	17.78
In a small country town or village	Count	3	0	0	5	8
	% category	37.50	0.00	0.00	62.50	100.00
	% of Total	6.67	0.00	0.00	11.11	17.78
In the outer suburbs of a city	Count	4	4	1	1	10
	% category	40.00	40.00	10.00	10.00	100.00
	% of Total	8.89	8.89	2.22	2.22	22.22
Total	Count	22	10	1	12	45
	% category	48.89	22.22	2.22	26.67	100.00
	% of Total	48.89	22.22	2.22	26.67	100.00

12.4 Victoria and Tasmania

The combined respondents from Victoria and Tasmania provide an interesting pattern of documentation issues across different locations.

Proportionately, large regional centres experienced significantly more problems than other locations with only 8.33% able to say they have never had such problems leaving 91.67% of people claiming negative experiences with documentation about residents' treatment while in hospital.

The next most problematic location is large metropolitan centres with 82.86% experiencing problems and some having these issues on a weekly basis.

VIC/TAS	*Frequency of care and treatment documentation problems*						
Location of facility		3-4 times in six months	5-10 times in six months	Weekly	Daily	Never	**Total**
A large metropolitan centre	Count	24	2	3	0	6	35
	% category	68.57	5.71	8.57	0.00	17.14	100.00
	% of Total	24.49	2.04	3.06	0.00	6.12	35.71

In a large regional centre	Count	8	3	0	0	1	12
	% category	66.67	25.00	0.00	0.00	8.33	100.00
	% of Total	8.16	3.06	0.00	0.00	1.02	12.24
In a small country town or village	Count	16	2	1	1	5	25
	% category	64.00	8.00	4.00	4.00	20.00	100.00
	% of Total	16.33	2.04	1.02	1.02	5.10	25.51
In the outer suburbs of a city	Count	18	2	0	0	6	26
	% category	69.23	7.69	0.00	0.00	23.08	100.00
	% of Total	18.37	2.04	0.00	0.00	6.12	26.53
Total	Count	66	9	4	1	18	98
	% category	67.35	9.18	4.08	1.02	18.37	100.00
	% of Total	67.35	9.18	4.08	1.02	18.37	100.00

12.5 Western Australia

Western Australian respondents from large regional centres all have experiences of inadequate documentation from hospitals about what occurred with residents during their hospital stay.

In large metropolitan centres 90.48% of respondents experienced such problems and from the spread of responses shown below, it can be seen that these experiences are quite frequent.

WA	***Frequency of care and treatment documentation problems***					
Location of Facility		3-4 times in six months	5-10 times in six months	Weekly	Never	**Total**
A large metropolitan centre	Count	13	5	1	2	21
	% category	61.90	23.81	4.76	9.52	100.00
	% of Total	30.95	11.90	2.38	4.76	50.00
In a large regional centre	Count	8	0	1	0	9
	% category	88.89	0.00	11.11	0.00	100.00
	% of Total	19.05	0.00	2.38	0.00	21.43
In a small country town or village	Count	0	0	0	1	1
	% category	0.00	0.00	0.00	100.00	100.00
	% of Total	0.00	0.00	0.00	2.38	2.38
In the outer suburbs of a city	Count	5	1	1	4	11
	% category	45.45	9.09	9.09	36.36	100.00
	% of Total	11.90	2.38	2.38	9.52	26.19
Total	Count	26	6	3	7	42
	% category	61.90	14.29	7.14	16.67	100.00
	% of Total	61.90	14.29	7.14	16.67	100.00

12.6 Qualitative themes

Of the total responses to the survey, 53% (*n*=197) provided written comments and of these only 5.01% (*n*=10) stated they had no issues to report or that documentation was sufficient.

12.6.1 Quality and extent of documentation related to hospital care and treatment of resident

It seems that lack of documentation is common in relation to details of medical, nursing and allied health professional care and treatment needed for ongoing care for older patients returning to residential aged care:

> *Documentation? Does this occur in acute settings? I'm beginning to doubt it does.*
>
> *What documentation re the medical and nursing treatment???*
>
> *No nursing or medical letters.*
>
> *Resident's returning from hospital WITHOUT documentation either nursing or medical is becoming more the rule than the exception these days.*
>
> *We never receive adequate or appropriate documentation. There are times when a resident is returned from hospital with NO documentation. ---------- Hospital is the worst.*
>
> *Insufficient details about the medical treatment and often no mention of the nursing care delivered.*
>
> *Often receive no transfer notes.*
>
> *Not enough information relating to the resident is given.*
>
> *Documentation is by far our biggest problem. It is none existent or very sketchy.*
>
> *No discharge notes. Arrive back at facility with a bang and no notes re treatment or follow up services.*
>
> *Either limited information or zero information.*

Many other comments with similar content were received but not included here.

Where documentation is received by the aged care home accepting care of the patient, the adequacy or relevance of information provided has been questioned by several respondents:

> *As stated before, quite often relevant documentation is not complete sometimes requiring multiple phone calls to ascertain the treatment the resident has received and any on-going treatment. This is particularly noticeable with any investigations carried out and the outcome of these investigations.*
>
> *The bigger the public hospital or private ones, the less information is received. Often, the continual treatment regime is never passed on.*
>
> *Sometimes information is not adequate for ongoing care of resident e.g. Discharge planners not completed properly or with incorrect information re medication etc.*
>
> *Nursing and medical summaries do not provide enough detail for an immediate comprehensive care plan to be developed. Often ongoing therapies and treatments are not included in the discharge documentation and some behaviours are not documented.*
>
> *We never receive medical documentation regarding treatment of resident while in hospital. It is particularly difficult when medication changes are made, but no order is forwarded on to the home. We are then expected to administer medications we have no order for. Discharge summaries from nursing staff are brief and provide no information regarding treatment or changes. You are never informed when bowels were last opened or when analgesia was last given.*

Issues arising from poorly prepared and confusing documentation were also raised by many respondents. A small selection of typical responses is shown below:

> *No discharge information at all. Sent the wrong papers on discharge, information was for another hospital patient (not our resident). Out of date information sent about people on discharge, and inaccurate information sent.*
>
> *This is the big problem. Never enough information. Illegible writing. Carbon pages not folded properly and writing over writing making reading impossible. This is the major issue. Communication.*
>
> *Documentation too limited and often not completed at all or correctly. Often no documentation re: diagnosis and treatment. Several times no documentation has arrived with transfer and is difficult to have followed up.*
>
> *More often than not medical/nursing discharge papers do not accompany the resident and staff have to chase up this is more frequent with (major metro hospital) than (another major metro hospital). There have also been occasional medication transcribing errors.*
>
> *Not able to read doctor's written notes on discharge sheet.*
>
> *Nearly every transfer has been accompanied by scanty notes, a lack of pathology results or x-ray reports.*
>
> *Transfer information often minimal and medication orders unclear or conflicting with prescriptions to pharmacy.*
>
> *As already stated, often there is no medical discharge letter sent; only nursing discharge. Often if both are sent, there are discrepancies in information provided. Often information provided can be very 'sketchy'.*
>
> *Difficult to read sometimes not comprehensive treatment plan in some cases.*
>
> *Transfer letter did not contain full details of treatment. No indication of whether resident's family had been notified of medical treatment provided.*
>
> *Very little information returns with the resident at times which can prove difficult if the resident is unable to tell you about their care, and if the GP was not the medical officer involved.*
>
> *Poor nursing documentation is always a problem.*
>
> *Nursing treatment tends to be losing quality, often residents return from hospital with either medical discharge or nursing discharge, not both!*
>
> *Misleading or incomplete medical histories. No CMA available. ACAT often have inaccurate diagnosis on forms or incomplete medical diagnosis on forms.*
>
> *Documentation incorrect, incomplete and with wrong name on it.*
>
> *Often scant details regarding significant medical events.*
>
> *Often does not describe confusion/behaviour or pressure management issues.*
>
> *Minimal information is sent back to us to provide the GP and how to manage the resident.*
>
> *Very little information imparted. Sometimes no discharge summary is sent so staff have to follow up.*
>
> *We rarely if ever receive adequate medical history - frequently the nursing discharge has been written by staff member who does not know the patient.*

Even when discharge and transfer information is received from hospital staff, many respondents commented on the confusing nature of inconsistent reports from different groups of hospital personnel and obvious differences between reports and the condition of residents arriving home:

> *Documentation hasn't arrived 3 times. Unsigned once. Regularly inaccurate re mental state. Unreadable medical notes. Contradictory allied health/medical notes.*
>
> *The medical transfer letter is either non existent or conflicts with the nursing transfer letter.*
>
> *Often nursing discharge medication summary doesn't match pharmacy discharge info.*
>
> *Inaccurate and incomplete history. Playing down of behaviours and adverse issues.*
>
> *Generally Nursing discharge summary is o.k. However medical summary is non existent or lacks adequate information.*
>
> *Limited medical information, usually not available until weeks after elder is returned. This is also the case for the treating Doctor. Nursing information is improving.*
>
> *Documentation from hospitals about medical and nursing treatment of residents may sometimes be adequate in regard to their current acute diagnosis. They are almost always lacking in providing a complete medical and nursing history of the resident.*

Attempts have been made by aged care staff to assist hospital personnel to provide relevant information about residents returning to their facilities. Many refer to a yellow envelope or history containing essential information about the person and their aged care needs, sent with the resident to hospital. It contains a section to be completed by hospital staff prior to discharge:

> *Often the "Yellow" Envelope (used to facilitate communication) is not used or completed by the hospital staff.*
>
> *We send a full history with the patient and often do not receive any feed back except medication.*
>
> *On most occasions the documentation is 'scant', and on occasions residents return with their medication documentation only.*
>
> *Missed information on documentation, medication, appliances, history all left off.*
>
> *No transfer documentation or directions on continued care or treatment received.*
>
> *Recent care not documented, no information on changes or special dressings etc.*
>
> *Discharge letter does not accompany resident and medication changes not documented.*
>
> *No clear information as to what had actually happened, treatment orders not always clear or complete. Medication orders not clear.*
>
> *Changes in medication are often very unclear i.e. they add [medications] but do not cease or note what [medications] should be ceased. Information may be a short as a one sentence discharge.*
>
> *Lack of correct medication orders. Lack of medical and nursing histories. Minimal nursing interventions.*

Again, aged care staff are often placed in a situation where they must follow-up these documentation issues with hospitals following residents' transfers:

> *Always requires phone calls to clarify issues re condition or treatment.*
>
> *Residents usually arrive with poorly completed transfer documentation or no documentation at all. Hostel staff spend precious time contacting the hospitals and chasing up information. There can be a 3 to 4 day delay in receiving information.*

Not all respondents experienced the problems shown above. A small group provided the following positive comments:

> *No problems. Our local hospital has developed an excellent system for documentation of transfers of residents.*

Documentation is usually good.

We always receive a medical and nursing discharge letter.

Mostly it has been up to scratch, on an occasion it is only the bare minimum requirements written and insufficient information provided to document.

12.6.2 Consequences of documentation issues

Comments provided by respondents need to be considered contextually with particular attention given to consequences arising from poor quality or absent documentation. Sometimes these consequences can be observed in delays in treatment being started; or a break in treatment that should be continuous; or reduced access to specialist treatment because appointments cannot be arranged; or confusion about medications prescribed in hospital but not legally able to be provided because of inadequate documentation received:

The documentation is really poor. As we are dealing with elderly most of the time they cannot retain information which is given to them in hospital so we really need it documented on transfer forms. The forms have limited information & sometimes illegible. We need to know about future appointments & sometimes why e.g. going to specialist to review dressing. Even future blood tests/pathologists for Warfarin patients. A history of why they were admitted & how we are to contribute to current care processes.

We receive a nursing and medical discharge letter. We often also receive enough medications for several days. But we are unable to give them without them being charted on our medication charts. This causes problems.

Usually discharge summaries are poor. Particularly from MO's and Allied Health. These people do not do discharge summaries on discharge but at a later date and send directly to the LMOs who, if the resident is being admitted for the first time, is often not the ongoing treating doctor.

Often discharged without medical letter outlining management, and nursing letter generally provides minimal information regarding nursing care, and does not outline treatments in any detail, if at all. Medication information is often incomplete or conflicting, and does not always clarify what meds are to continue on discharge or cease e.g. anticoagulant therapy, opioid pain meds etc.

There seems to be little understanding from hospital staff that when residents are transferred to aged care, they are assessed in terms of their aged care needs and when medical treatment needs to be maintained, this is incorporated into the planning process. When inadequate, inconsistent or incomplete information is provided, this care planning process, essential to the ongoing wellbeing of residents, can be compromised:

Information provided is usually too brief. Residential care staff need more information to properly plan appropriate ongoing care. It is also important that the residential care facility is informed about all medical conditions.

Very sketchy information even after surgical procedure, conflicting information, no copy of transfer letter given, no copy of hospital medication chart, little info on when bowels last opened, items left behind in hospital.

Often information is not sufficient and staff have to spend time contacting the hospital to clarify treatment regimes. Hospitals have also discharged clients who are too ill to be cared for at our facility, back to the unit with no discussion with staff here.

Once no prior notice of resident taking cytotoxic medication therefore delay in organising appropriate equipment for waste disposal.

Lack of understanding of the referring hospital relating to the knowledge base of the PC's in hostel.

> *Not enough information of the type that relates to assessments that we use in the aged care industry. Hospital staff not acknowledging our need for information.*
>
> *Often no discharge summary accompanies patient and is faxed later, this causes a problem if meds are changed and the GP has already visited and is unaware of the new regime. He then does another visit to rewrite up the new changed meds.*

Comments were also received that highlight the focus of aged care efforts in preventing further health breakdown, something more difficult to achieve when details of recent health crises are unknown:

> *Often the client's condition has changed since the initial ACAT assessment and at times discharge information contains only the present status, it does not describe the in-between. It's often the in-between events that provide insight into the client's condition and can be used to avoid further acute admission.*

12.6.3 Reasons for documentation problems

Respondents through their comments have tried to understand where the system may be weak in relation to moving timely and accurate documentation between hospitals and aged care services. The selection of responses shown below provides some ideas as to perceived weaknesses in the system. Assumptions made by hospital staff about aged care services can impede efforts in professional communication as shown below:

> *Mostly only basic info - expectation is probably that if resident was originally from RACF then status would already be known.*
>
> *We always send a transfer letter and nursing summary along with Palliative care wishes. At least 50% of calls from the hospital could have been answered if they used the information that has been sent with the resident.*
>
> *Documentation often does not come with the resident. Also if we send a resident to hospital we often get telephone calls asking for information that we have already provided.*

Some respondents noted a level of reluctance by hospital staff to accept responsibility for documentation. In some instances it depends on the mood or willingness of hospital staff to provide professional standard documentation to aged care services:

> *It is very common to have no paperwork with the admission. They always blame the ambulance guys not picking it up.*
>
> *They forget to send discharge letters.*
>
> *The R.N. on duty either forgets, or cannot complete due to busy commitments.*
>
> *On one incidence I was informed by hospital staff I did not need to know what had occurred while resident in hospital and as long as medication list written, posting discharge summary would be adequate.*
>
> *Some hospital staff do not give us any documentation. This documentation is available and some staff are very good and do it all when they send the person back, but others just do not bother.*
>
> *Often not a good summary depends on doctor, nursing staff and hospital. Some ok others lacking greatly.*

Widespread misunderstanding by hospital clinicians of legal obligations in relation to health records appears to be impeding other professionals who 'need to know' details so that they can ensure continuity of care and treatment:

> *Incomplete picture presented. On several occasions when we contact the referring hospital for further information we get response "due to privacy legislation we cannot give you this information". I believe there is a poor*

> *understanding by many staff of the intent of this Legislation as it does not mean that we do not receive the information necessary to provide ongoing care.*

Ageist attitudes of hospital staff emerge again in this issue category. The comment below is typical of those received in relation to poor attitudes by hospital clinicians towards older patients and services providing care for older people:

> *Very poor return rate and quality of info is also very poor. Some documentation is very rude (with the implication that we caused the presentation to hosp, or that the presentation was a waste of time). Yellow envelopes are being sent to hosp, but not returned. A lot of the implication is that this is just an old person "clogging" up the acute system.*

As services working to provide a continuum of care with hospitals, respondents are of the view that hospital clinicians must work in chaotic systems that prevent planning, management and basic safety strategies to occur. The result is a lack of professional standards, little effort in due diligence and a practice of shifting of responsibility for hospital-initiated problems onto aged care services:

> *Unless a staff member attends the hospital documentation can be patchy and especially on Friday afternoons if they have to send a resident back to the nursing home because of staff issues at the hospital.*
>
> *The time from decision to discharge to transfer is so short that doctors don't get to document their hospitalisation so that it goes with the resident. Faxed information by doctors often arrives 24 hours later. Simple domains of bowels and dressings and mobility are often incorrect or missing.*
>
> *Nursing care is often not clear or has not been completed. Nursing transfers are often filled out by more than 1 nurse and some of the information is 'old' information from when transfer summary was commenced. Patient may not have been discharged for days/weeks after commenced and care is not updated by nurse in charge of actual discharge. Very often nursing information does not agree with medical information and it is necessary to contact hospital for clarification.*

12.6.4 Strategies to overcome problems with hospital documentation of care and treatment

Because accurate documentation about hospital treatment is so important to aged care services when organising ongoing resident care, several respondents shared their strategies for dealing with less than optimal efforts by hospitals in relation to their documentation practices.

There appears to be an expectation by hospital nurses in particular that aged care staff spend time following up on incomplete or inaccurate hospital discharge documentation:

> *Very, very little information documented, usually it has been written at the end of a tick sheet: Any problems contact Ward.....*

As it turns out, many respondents see little alternative to the time-consuming and frustrating option of telephoning hospitals and locating someone who might be able and willing to provide essential details about patients they recently discharged.

Obtaining adequate nursing documentation on discharged residents can involve aged care staff telephoning and even travelling to the hospital, or working with hospital clinicians and managers to help them sort out their protocols:

> *Care plans for wounds etc not documented therefore care staff spend time following up to gain correct information.*
>
> *What documentation? 2/3 times a medical discharge is provided by the doctor however no nursing discharge information is ever received.*

> *Nursing documentation is often insufficient, but with the work we are doing we have managed to gain improvements. Medical transfer letter is good when we get it but was frequently delayed or did not arrive. Since the action group meetings we now get the letter either with the resident at transfer, or faxed through immediately after.*

Obtaining adequate allied health documentation can be as difficult as obtaining adequate nursing information:

> *Staff here have had to ring up to clarify some details or request documentation e.g. speech therapy assessments and recommendations, case history details.*
>
> *Required to request physio, OT etc reports. Each admission returning to facility, minimal information sent.*

Obtaining adequate medication documentation is made more difficult by the stringent legal requirements attached to valid prescriptions. Comments below indicate the time-consuming efforts that aged care staff need to undertake to obtain this documentation in a form that can be used:

> *Documentation related to medication was not designed for aged care facilities with such strict guidelines in place. Communication with pharmacist has been good.*
>
> *We don't have huge numbers of admissions but in at least 95% of residents returning from hospital there is insufficient or no documentation including a medication chart. We are working with our GP liaison doctor to rectify this as she also is involved with the hospital.*
>
> *Poor or even absent information relating to treatment & care whilst in hospital and no information relating to medication changes and the reasons for such changes. The public hospitals have been improving due to local initiatives but private hospitals remain a problem.*

Obtaining adequate medical documentation poses similar hurdles to that of other hospital clinical and therapy personnel. Mostly the issues for medical documentation relate to unexplained delays:

> *Doctors rarely complete discharge plans and the information derived from nursing discharge notes is inadequate. When information is insufficient and staff ring the Hospital with queries, notes are not available or staff who were caring for them have finished their shift.*
>
> *Information was not made available until after transfer - would have been helpful to have transfer letters etc faxed to us prior to admission.*
>
> *Sometimes the medical transfer is not exhaustive but the ACAT makes up for this.*

Accessing investigation reports in a timely way can enable aged care providers and families to avoid costly duplication of investigations that were done in hospital. Again delays in locating and then accessing the documents seem to be an issue:

> *Incomplete or non existing transfer forms from hospital. Finding of tests not provided, tests conducted not provided implications of conditions in laymen terms not provided for explanation to clients who may have questions. Follow up requirements not provided.*
>
> *Local private hospital generally very good. Local public hospital and public hospital [medium distance] kms away virtually never give adequate or timely documentation about treatment, procedures, and medication changes.*
>
> *Facility usually has to chase up documentation. Test results very rarely come back with a resident.*

Post-discharge follow-up by aged care staff is the practice rather than the exception when accepting transfers from hospitals. In most instances it is aged care staff who follow-up on deficiencies in hospital discharge and transfer documentation:

We had one incident where we had to wait for the following day to receive faxed information, but had received verbal information.

Are discharged without a medical discharge summary and with a great deal of time spent chasing orders etc. Often weeks go by without receiving a summary.

Often the Dr's letter does not come with transfer and the nursing transfer letter is usually only half filled in, with no documentation re behaviours even when resident had guard whilst in hospital. Often staff have to ring hospital to find out the details of treatments and any ongoing issues.

We do not always receive all documentation sometimes nursing letters or doctors' letters are not received and we need to get them to fax us a copy.

In some cases we are required to ring the hospital to clarify gaps in documentation.

Residents are returned to facility without any paperwork, or only a nursing summary. Facility staff spend time chasing up information to enable them to provide appropriate care.

Our facility has to ring the hospital and specifically ask for information and then usually you only get a verbal handover.

The standard of documentation from acute care facilities has improved quite a lot over the last 2 years. There is a lot more clarity in information due to printouts rather than handwritten case notes.

We have to "force" hospitals to send transfer documents - have to chase up. Also the same with medications.

It usually arrives with the resident - but they will give a verbal handover if we ring.

Many hours spent trying to obtain information from acute care staff - as documentation either conflicting or missing.

Shorthand not accurate. Usually lacking detail. Requires staff of this service to have to spend time trying to get accurate information and relevant hospital people to talk to.

Residents have returned to the facility with no documentation at all and we have had to call and request information to be faxed through. Although then we have had some very good discharge information.

No discharge summary sent. Incomplete summary sent. Staff need to phone hospitals and get summary faxed to facility.

One respondent suggests that a standardised protocol could assist hospitals to overcome what seems to be a muddled approach to discharge documentation:

Would be great if there was only one form that every hospital used so when we receive a resident from hospital the one form would be able to give us all the information.

12.7 Summary and recommendations

Most respondents to this survey have experienced problems in discovering what may have occurred to residents while they were in hospital. A major issue is the poor quality of documentation received, if it is received at all, relating to inaccuracies, inconsistencies on important treatment orders, illegible writing and faxed copies, confusing and unrealistic recommendations and no indication as to how these matters can easily be followed up.

The reasons for such low standards of hospital documentation are believed by respondents to be associated with a misunderstanding of legal requirements in documentation and who should have access; ageist attitudes of hospitals staff which leads them to neglect documentation related to aged care; and reluctance of hospital staff to accept responsibility for accuracy and quality of documentation related to resident transfers.

Consequences related to issues outlined above include hurdles to delivering continuity of care and treatment as well as planning strategies to prevent a repeat of problems which led to hospital admission.

12.7.1 Recommendations

Improve hospital documentation systems. As part of a joint quality improvement committee aged care and hospital staff could devise appropriate documentation and transfer systems to overcome obvious flaws in current arrangements and meet the needs of both services.

Establish a hospital contact person who would be able to follow-up on documentation deficiencies without aged care staff having to divert resources to searching for clinicians and obtaining copies of basic information.

13 Information provided by acute care personnel to residents' families prior to arriving at your facility

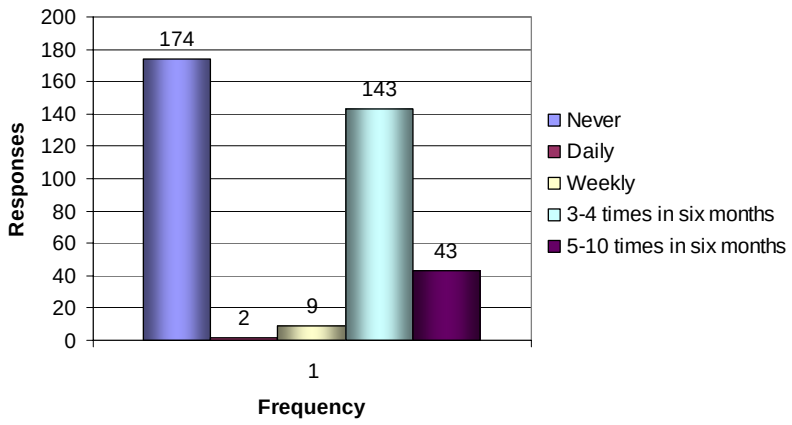
Throughout the areas of concern detailed above it is apparent that communication flows between hospitals and aged care staff can, at best, be described as patchy.

Often people working in aged care find it necessary to rely on relatives to provide essential information on the care and treatment of residents returning from hospitals. Sometimes information is refused to those taking over the care of residents and only provided to family members who may or may not remember details provided by hospital staff.

It is also crucial that families be provided with accurate and up-to-date information by hospital staff about what aged care services entail and what can realistically be expected of care and treatment services provided in that environment.

In 47% (n=174) of responses, no problems were reported concerning information provided by hospitals to relatives of residents in their care. However, the remaining 53% (n=197) did have problems in varying intensity with the most commonly reported frequency being up to 4 times in a six month period (or around every 6 weeks). Around 15% of respondents had a much more frequent experience of this problem.

Problems with information given by hospitals staff to families prior to transfer to aged care



13.1 New South Wales

NSW respondents from country towns seem to experience fewer problems than most with information provided by hospitals to residents' relatives.

From the table below the city areas appear to be seen as much better at including families in information about residents than other locations. Respondents able to say they have never had problems with this aspect of hospital transfers are in large metropolitan centres (58.97%) and outer suburban areas (60%).

The next group is from regional centres (50%) and the least positive group of respondents are from country towns where 45% claim never to have had problems.

NSW	*Frequency of problems with information given to families*						
Location of facility		3-4 times in six months	5-10 times in six months	Weekly	Daily	Never	**Total**
A large metropolitan centre	Count	8	6	1	1	23	39
	% category	20.51	15.38	2.56	2.56	58.97	100.00
	% of Total	8.00	6.00	1.00	1.00	23.00	39.00
In a large regional centre	Count	8	1	1	0	10	20
	% category	40.00	5.00	5.00	0.00	50.00	100.00
	% of Total	8.00	1.00	1.00	0.00	10.00	20.00
In a small country town or village	Count	5	1	0	0	5	11
	% category	45.45	9.09	0.00	0.00	45.45	100.00
	% of Total	5.00	1.00	0.00	0.00	5.00	11.00
In the outer suburbs of a city	Count	7	5	0	0	18	30
	% category	23.33	16.67	0.00	0.00	60.00	100.00
	% of Total	7.00	5.00	0.00	0.00	18.00	30.00
Total	Count	28	13	2	1	56	100
	% category	28.00	13.00	2.00	1.00	56.00	100.00
	% of Total	28.00	13.00	2.00	1.00	56.00	100.00

13.2 Queensland

Queensland respondents present a less positive picture in the table below however significant proportions of respondents from every location say they have never had problems with hospital information to families. Large metropolitan centres (63.16%) and large regional centres (66.67%) experience the highest level of respondents experiencing such problems while respondents from country towns reported similar experiences (57.9%). Just over half (52.38%) of respondents from the outer suburbs of Queensland cities reported having problems with information given to families by hospital staff.

QLD	*Frequency of problems with information given to families*					
Location of facility		3-4 times in six months	5-10 times in six months	Weekly	Never	**Total**
A large metropolitan centre	Count	10	2	0	7	19
	% category	52.63	10.53	0.00	36.84	100.00
	% of Total	11.63	2.33	0.00	8.14	22.09
In a large regional centre	Count	11	7	0	9	27
	% category	40.74	25.93	0.00	33.33	100.00
	% of Total	12.79	8.14	0.00	10.47	31.40
In a small country town or village	Count	8	3	0	8	19
	% category	42.11	15.79	0.00	42.11	100.00
	% of Total	9.30	3.49	0.00	9.30	22.09

In the outer suburbs of a city	Count	7	3	1	10	21
	% category	33.33	14.29	4.76	47.62	100.00
	% of Total	8.14	3.49	1.16	11.63	24.42
Total	Count	36	15	1	34	86
	% category	41.86	17.44	1.16	39.53	100.00
	% of Total	41.86	17.44	1.16	39.53	100.00

13.3 South Australia

South Australian respondents seem to be divided according to whether the location is city or country. Large regional centres (62.50%) and country towns (62.50%) reported similar levels of being able to say that they had never experienced problems in this issue. The frequency distribution between these two locations varies a little but overall they are similar. It seems that over half the respondents from large metropolitan centres (52.63%) have difficulty with information provided by hospitals to families and in suburban locations, this level of reported difficulty rises to 60% of respondents.

SA ***Frequency of problems with information given to families***

Location of facility		3-4 times in six months	5-10 times in six months	Never	**Total**
A large metropolitan centre	Count	6	4	9	19
	% category	31.58	21.05	47.37	100.00
	% of Total	13.33	8.89	20.00	42.22
In a large regional centre	Count	2	1	5	8
	% category	25.00	12.50	62.50	100.00
	% of Total	4.44	2.22	11.11	17.78
In a small country town or village	Count	3	0	5	8
	% category	37.50	0.00	62.50	100.00
	% of Total	6.67	0.00	11.11	17.78
In the outer suburbs of a city	Count	3	3	4	10
	% category	30.00	30.00	40.00	100.00
	% of Total	6.67	6.67	8.89	22.22
Total	Count	14	8	23	45
	% category	31.11	17.78	51.11	100.00
	% of Total	31.11	17.78	51.11	100.00

13.4 Victoria and Tasmania

Respondents from country towns and outer suburbs of Victoria and Tasmania seem to be far more positive about information given to families than respondents from larger centres. By far the most positive are those from small towns with 52% saying they had never had any problems with information provided by hospitals to families. A high proportion of large metropolitan area respondents (65.71%) report problems, some occurring quite often. In regional areas the level claiming problems reaches 66.67% however they do not occur as frequently as in metropolitan centres. In the outer suburbs respondents report a level of 53.85% with difficulties in this issue.

VIC/TAS		*Frequency of problems with information given to families*					
Location of facility		3-4 times in six months	5-10 times in six months	Weekly	Daily	Never	**Total**
A large metropolitan centre	Count	19	2	2	0	12	35
	% category	54.29	5.71	5.71	0.00	34.29	100.00
	% of Total	19.39	2.04	2.04	0.00	12.24	35.71
In a large regional centre	Count	7	0	1	0	4	12
	% category	58.33	0.00	8.33	0.00	33.33	100.00
	% of Total	7.14	0.00	1.02	0.00	4.08	12.24
In a small country town or village	Count	10	1	0	1	13	25
	% category	40.00	4.00	0.00	4.00	52.00	100.00
	% of Total	10.20	1.02	0.00	1.02	13.27	25.51
In the outer suburbs of a city	Count	11	2	1	0	12	26
	% category	42.31	7.69	3.85	0.00	46.15	100.00
	% of Total	11.22	2.04	1.02	0.00	12.24	26.53
Total	Count	47	5	4	1	41	98
	% category	47.96	5.10	4.08	1.02	41.84	100.00
	% of Total	47.96	5.10	4.08	1.02	41.84	100.00

13.5 Western Australia

In Western Australia where most responses are from large metropolitan centres, 61.90% reported problems with information provided by hospitals to families and this seems to occur often. It also occurs in large regional centres with two thirds of those claiming experience of similar problems. The most positive feedback was received from outer suburbs respondents of whom 72.73% say they have never experienced such problems with information given to families.

WA		*Frequency of problems with information given to families*				
Location of facility		3-4 times in six months	5-10 times in six months	Weekly	Never	**Total**
A large metropolitan centre	Count	9	2	2	8	21
	% category	42.86	9.52	9.52	38.10	100.00
	% of Total	21.43	4.76	4.76	19.05	50.00
In a large regional centre	Count	6	0	0	3	9
	% category	66.67	0.00	0.00	33.33	100.00
	% of Total	14.29	0.00	0.00	7.14	21.43
In a small country town or village	Count	0	0	0	1	1
	% category	0.00	0.00	0.00	100.00	100.00
	% of Total	0.00	0.00	0.00	2.38	2.38
In the outer suburbs of a city	Count	3	0	0	8	11
	% category	27.27	0.00	0.00	72.73	100.00
	% of Total	7.14	0.00	0.00	19.05	26.19

	Count	18	2	2	20	42
	% category	42.86	4.76	4.76	47.62	100.00
Total	% of Total	42.86	4.76	4.76	47.62	100.00

13.6 Qualitative themes

From the total responses received, 36.93% (*n*=137) volunteered comments on the issue of information provided by hospitals to families of patients prior to their transfer to aged care. Of these 9.48% (*n*=13) claimed that they had experienced few or no problems in this regard.

13.6.1 Pressure placed on families

Family members work closely with aged care staff to provide a quality of life for residents that prioritise their social, physical and care needs. In many instances trust relationships that build between care staff and family members as partners in care engender confidence that the resident is living life with an optimal level of contentment. It is because of this shared interest in the welfare of residents that families often discuss what they see happening to their relative while in hospital and also to seek clarification from aged care staff whom they trust, about aspects of hospital practice they do not understand.

Throughout stressful experiences associated with having a relative in hospital, aged care staff are empathetic towards family members:

> *This is a difficult question as families are bombarded with information are they just not able to comprehend the large volume of information relayed as well as cope with what is probably a catastrophic event to their family member.*
>
> *The majority of families report that unless they actively seek information, they do not receive it, and on many occasions the information they receive from one staff member conflicts with that given by another staff member. Families regularly telephone the facility to request our Registered Nurse to seek information from hospital care staff.*

Information is often given by hospital staff to families rather than aged care providers who also need information that will help them provide appropriate ongoing care:

> *Families are often told more than the facility and then expect staff to be as informed.*
>
> *Often families are given more information than we are, and sometimes this can be a problem if families don't understand what they are being told. We do go and visit people in hospital and encourage families to talk to us.*
>
> *Information is provided to some families but not provided to us. This makes us rely on what the families are telling us which can often be misconstrued.*
>
> *Terminal care wishes and other directives not always documented but family members report that they have discussed with hospital staff.*
>
> *Would not know as they do not even ring us when they have died - it is usually the family they contact and they forget all about the facility. This question you will have to ask families.*
>
> *Families sometimes don't understand information given & can relay it incorrectly. Families tend to panic & expect hospital care from the facility. Families also tend to tell you what they think is important about the residents health, which can sometimes differ from what the facility actually needs to know.*
>
> *Families told something different from documentation, or families have more info than facility, families having difficulty talking to medical staff*

about resident's progress and planning, Dr not contacting families at all even when in a private hospital.

We usually get best information from families – who then wonder why the hospitals have not spoken to us.

Often more information can be gleaned from the resident's family than the discharge summaries!

Mixed message from Hospital to family and family to facility. Needs to be in writing so no confusion arises.

In some instances families are put under pressure to make life-changing decisions about their parent; or have their experiences dismissed out of hand; or become overwhelmed by technical details with no explanations from hospital staff. It is not surprising that families can feel disempowered by such interactions:

One daughter felt that acute care personnel did not believe her when her mother was confused and dementing and fantasizing

This is often a huge issue - the families are stressed out at the pressure they have been put under to "accept a bed at first facility available as need for the next pt." Many a time we deal with distressed families who need referral to Social Workers to deal with issues around loss, grief and guilt. It does not seem to be considered important to support the family in what is often a very difficult time for them.

On occasions the family contact us to know what is going on. They comment that no one in the hospital knows what is going on - there are too many people involved, and they cannot get answers. (It needs to be remembered that the children of some of our residents are themselves elderly - in their 70's and may experience difficulty hearing and/or understanding).

The time spent by relatives trying to comply with demands placed on them trying to find suitable accommodation with little or no help must be terrifying for everyone.

In this comment, someone working in the hospital directed a family member to complain about aged care staff but instead, the situation was brought to the attention of RACF staff:

Told single room then offered a double. Hospital staff have told families to attend at meals or resident won't be fed. Families told to complain about aged care staff.

13.6.2 Issues with accuracy of information provided

Misinformation given to families by hospital staff can be a source of distress for all concerned.

The selected comments below demonstrate the extent of ignorance among hospital staff dealing with or making comments about the aged care system:

Acute care staff are not able to provide reliable information as many of them have no knowledge of residential care facilities.

Families are often told that residents are not suitable to return to this facility. The problem being the hospitals are not aware of the care that can be provided by this facility. One family reported that their diabetic father did not receive diabetic medication for several days while in hospital.

Rarely a problem re resident related info. Often inappropriate info given to relatives about the aged care facility.

Acute Care staff have misled relatives in relation to what services we provide and financial matters.

Sometimes feel the hospitals have no idea of what happens in a nursing home. Often tell relatives the wrong information about funding etc.

Often there is conflicting information given to families.

> *Acute care staff seem to have little understanding of aged care.*
>
> *Varies. Bigger public or private hospital, the less information is received.*

Several respondents report instances of hospital staff providing misinformation to families in an attempt to either cause distress to the family or to discredit the aged care industry. In one of the larger hospitals this phenomenon is reported to exist even outside services directly linked to aged care:

> *Families are told inaccurate information by hospital - e.g. Has been constipated so that caused the problem when this is not the case. One family was told that "three residents from our facility had falls in one night therefore it must be a bad place" - Actually one was a fall and the others had medical conditions ice TIA and cellulitis*
>
> *Information can be negative. The same old story " nursing homes are awful, understaffed, untrained staff, etc" However, I do have to comment that [geriatric unit in large metropolitan hospital] is far better than other wards as it is a geriatric ward and we have a very good working relationship with them most of the time. They have computer generated reports and know exactly what we need for the new admission to run smoothly.*

Hospital staff are perceived by some respondents to be somewhat confused about their legal responsibilities in relation to privacy and confidentiality. An alternate interpretation of comments below would be that hospital workers do not know and can not provide basic details of the patient they care for:

> *Our residents often do not have family involved and the manager therefore becomes the clinical advocate. I visited a resident in ICU yesterday and the nurse was not able to tell me the diagnosis of her patient. Also did not want to speak to me for privacy reasons although we had to care for him and he does not have relatives.*
>
> *Very little info provided, either because the person caring for the resident on the day has had little contact of knowledge of previous management or discharge planning, or because facility is not seen as entitled to info, only family are. Despite frequent contact from hospital to get information already provided in transfer documentation, there is rarely initiation of contact by hospital to advise of progress or discharge.*

13.6.3 Consequences of misinformation provided to families

It is not clear from the comments received whether hospital staff deliberately mislead families and aged care providers by making false and inaccurate statements about services provided in aged care homes, or whether the statements arise from ignorance about aged care. It is possible that this trend relates to a desire by some hospital staff to process older patients through the hospital system as quickly as possible (as discussed above in several of the related issues); or it could be a misguided manifestation of competitive spirit felt by some hospital staff in relation to other health services.

Whatever the motivations that may prompt hospital workers to spread misinformation about aged care, the consequences for families and residents are seen in enhanced difficulties in adjusting to placing a relative in care. The building of a crucial trust relationship between families and aged care staff can be undermined by mischievous comments by hospital staff:

> *They do not always tell them the truth if they are seen as difficult relatives; this makes it difficult for the home and GP. Often registrar and nursing staff are stating the nursing home is terrible as this person should not be dehydrated. Building the relatives confidence up (as the relative is seen as difficult or has unrealistic expectations) by saying we will have 1 nurse to look after the relatives loved one. Then we have to manage the aggression from relatives, because "that's what the hospital said".*

Families do not understand the information they are given. Families are given gratuitous and wrong information about what a home should do. Families are ignored with the excuse that the patient is in a home and the home gets the information. But the hospital staff then fail to give the home the information either, and this can be damaging to the relationship between the home and the family.

Families not informed of resident returns. Families not aware of decision made esp. NFR. Families being told this or that should not have happened in aged care or why this and that was not given in aged care by the doctor in hospital making families start to question the care and routine at the facility. It is very difficult for the facility to try and understand why hospital staff who only just met the resident and relatives putting blame and doubt into the relatives' mind.

The families tend to trust all information given to them by acute care staff and devalue that which is offered by aged care facility staff. Advocating for the safety of clients is extremely difficult as a result of this [reference to restraint-free environment].

Major problem - very misleading advice given to residents' families especially where residents are not able to return to a low care facility e.g. cannot weight bear. Absolute lies told to families and hostile attitude towards facility staff.

In some instances there has been misunderstanding created between hosp. and RACF and family with hosp. Staff commenting on the "lack of care" received by resident in the RACF which is not the case/causing distress to family. It would be best if there is a clear communication between hosp and RACF if there are any issues they noticed on admitting our residents.

Families have been give wrong info such as "Your mother was dehydrated or your mother has ...."

Sometimes the family will tell us more than the hospital. Or the family will give us the impression that the hospital thought the presentation was our fault, or a waste of time.

Distress to families caused through conflicting information and outright accusations made by hospital staff against aged care homes was commented upon by several respondents who also expressed concern that families were disempowered by the practice of some hospitals taking unilateral decisions about discharges and transfers:

Lack of counselling re realistic treatment for chronic disease. No direction on palliative approach.

Conflicting/misleading information given. Families confused and anxious.

Family not informed of discharge. Family not consulted about medical issues and life choices.

Families not informed of required care and expecting alternative outcomes.

Often the families are given conflicting information about why their relative needs to be transferred to an aged care facility or how the treatment/management of the person will change.

Information offered to resident families is often not explained properly leaving them confused as to their loved one's condition. Have had families ringing looking for family member who is still in hospital but have been told by hospital they have been returned. Resident was transferred to another hospital, not back to facility.

By promoting negative attitudes by families about services offered by aged care homes, hospital staff seem unaware that in time, the truth of the situation will emerge. Once families realise they have been duped they will not regard future hospital advice as credible. In fact some families are reported to have taken more formal steps to complain:

Families have written formal complaints to the patient advocate of the hosp re poor hospital care

We have had complaints from families about the lack of detail provided by hospitals.

Differences in funding of aged care and the acute hospital system are not well understood by many of hospital staff associated with respondents to this survey. Lack of accurate information however does not seem to impede some hospital staff from expressing their views as to what families should expect when moving their relative to residential aged care:

Occasionally families are surprised to find that they are required to pay for care in our facility and most times once this is explained, there are no issues. A very low minority believe that this is a charge that is due to our facility being privately owned and despite being advised that charitable sector facilities would charge the exact same amount, they are unwilling to believe this.

Main problem relates to hospitals not understanding the scope of service delivery skills mix in the aged care facilities. E.g. one resident's family was told the facility would have a physiotherapist available every day when in reality the physio comes for 4 hours once a week. It means family's expectations are often unrealistic.

Hospital staff have no idea what happens in an Aged Care Facility. They do not understand the financial constraints, staffing levels and numbers; equipment or that we do not have doctors, pharmacists or dietician on site or on our pay role.

Hospital discharge staff have a poor understanding of the funding process, the difference between high and low care and what our particular facility can offer the resident. Families have been confused and sometimes disgruntled at the inconsistency of what they were told and what actually happens.

Poor understanding of the funded levels of high care and low care and the difference in the facility's ability to care for the resident in relation to staffing, financial, environmental and equipment resources.

Some unrealistic expectations generated by hospital staff comments to families seem on face value to be quite cruel. For families to access special extras such as intensive rehabilitation they would need to spend considerable money and even then, it is not always possible to access these services in some regional locations:

Families arrive with unreal expectations about services that can be provided. Like being told that their relative will be rehabilitated to the same level as a proper rehab unit.

Relatives were given the expectation that "special equipment" such as particular types of "water beds" etc would be provided by the N/H. On relative was told that her mother "needed" high care because she was having falls and this would not happen in a N/H where there was 24 hour care.

The biggest problem relates to availability of intensive physio which acute staff often say the client needs and which will be provided which we do not do. Other issues relate to fees rather than medical issues.

Often give relatives information regarding extensive rehabilitation that is not always possible - gives relatives unreal expectations and arrangements until discharge imminent. Information on resident discharge may be inappropriately directed at reception staff, instead of nursing staff who can clarify any care needs if applicable.

Relatives are sometimes given information that care can be delivered but that care is unable to be delivered at times due to resources not being available.

13.6.4 Concern shown for relatives

Family-centred care is a cornerstone of aged care practice. Essentially this approach to care demonstrates concern for families who find they must access residential aged care services and often following long periods of providing care to their loved one at home. This is a very emotional transition for many families who naturally would prefer that their relative not require such services.

When residents require the services of acute hospitals for some health crisis that has occurred, families are deeply affected and require support and assistance in understanding what is occurring as well as adapting to the realities associated with the situation.

Respondents provided comments on how relatives were treated by hospital staff during periods of hospitalisation of their loved one:

> *Families often let us know that the hospital keep them in the dark & do not tell them everything that is going on. On occasion they do give good reports about hospital info.*
>
> *What family? The assumption is made that the facility will contact the family once they arrive back in the facility. There appears to be little communication with the family during their hospital stay,*
>
> *Residents often report that they did not understand the issues, or that language barriers with medical staff made it difficult to understand the issues affecting their family member.*
>
> *Information supplied to relatives varies, depending on relative enquiries. Most relatives advise that it is difficult to contact doctors during the hospital stay. Private hospitals and doctors are better in this area.*
>
> *Relatives often confused and not treated well.*
>
> *Sometimes relatives are unaware of return.*
>
> *Families not always informed of transfer back to facility from public hospitals.*
>
> *One time family not satisfied with lack of information from Dr or nursing staff*

Several respondents indicated that information needs of families are not a priority for hospital staff dealing with their elderly relative. Comments indicate that some families seek support and assistance from aged care staff in the hope of accessing useful information about their hospitalised relative:

> *Occasionally residents ring us from the hospital for info.*
>
> *In some instances the communication was very limited leaving family members to rely on the hostel staff to obtain the relevant information.*
>
> *We often get families coming into us to explain what is happening at the hospital and for reassurance that they are making the right decisions for the family member. It is clear at times that the explanation given at hospital left a lot to be desired and no one is aware that the family is misunderstanding or is not aware of their rights to fight for them.*

Several comments indicate apparent reluctance by hospital staff to speak with family members about what is happening to their relative:

> *Hospitals reluctance to give information to family members - reason given is confidentiality. Follow up care hasn't been communicated.*
>
> *Residents' families comment they receive minimal information on their family member if any at all!*
>
> *It is assumed the Facility is the "Person Responsible" and family doesn't get told the information on discharge.*
>
> *Most social workers are interested in getting the patient out of the hospital to free up beds and the families are sometimes the last to know.*

> *The families are usually the last to know and their information is filtered rather than transparent.*

Significant aspects of hospital treatment and care are also not well communicated to families. Movements of patients to and from hospitals and transfers to aged care services frequently need to involve family members but from comments received, it seems that families are not always included in hospital decisions about discharges and transfers:

> *There have been times when families have not been told of the return and not happy about the timing of the return.*
>
> *The hospital has contacted the resident's family to bring them home on discharge, but have not given any information to the families.*
>
> *Resident transferred to hostel (low care). Family unsure about what was happening. We needed to inform family that resident had arrived.*
>
> *Timing of transfer seems the biggest problem for families.*
>
> *Relatives not notified of transfer. Relatives not notified of care provided.*
>
> *In some instances no contact with family.*
>
> *Family not involved in transfer decisions.*

Hospital decisions to transfer an elderly, frail person to residential aged care often occurs quickly and from comments provided by respondents, often these decisions are taken without due consultation with families. It is quite worrying to see comments indicating that not only is the decision to transfer not fully understood by families, the reasons for transfer to aged care are also not always made clear to them:

> *Frequently the families are uneducated about the patient's diagnosis and prognosis.*
>
> *Lack of discussion re poor prognosis.*
>
> *Indications are that they are never told anything about pt condition. No one tells them anything.*
>
> *One family member was not as aware as they should have been about her relative's terminal condition. Probably some denial but this had not been identified by hospital staff.*
>
> *Families unaware of date and time of transfer back. No information provided to family re treatment whilst in hospital and follow up or palliative care needs.*
>
> *Hospital staff leave it up to Aged care facilities to inform family members of palliative needs.*
>
> *Families often arrive under the impression that their loved one is being admitted to a nursing home because of the medical condition they were being treated for in hospital. In many cases this is not correct. Families are also often under prepared with regards to what items and personal belongings they can have at the nursing home - in some cases they have advised us that they had been informed by the hospital on what not to bring.*
>
> *The families are frequently not told of skin breakdown, tears, bruising and poor nutritional status.*
>
> *Hospital do not let families know of pressure areas and when they are sending the resident back to the facility.*

13.6.5 Strategies

Concern for families based on all the issues outlined above, prompts aged care staff to devise strategies that might relieve some of the stress and anxiety associated with having a relative in hospital while not being able or confident enough to get information from hospital staff.

On two occasions when a relative was concerned re information being received from the hospital we have supplied clinical advocates for the residents concerned. On one occasion we supplied both a clinical and administrative advocate.

The hospital never provides information to family unless they are with the resident at the time and then most families state that they did not understand. It is left to staff from our facility to contact the family and discuss changes if we are aware of any. Our staff also contact the resident's general practitioner.

We usually follow up the family as soon as we know they are being admitted rather than rely on hospital staff giving the wrong information.

We contact hospital to find out.

We liaise with the hospital staff directly.

I usually liaise with the hospital staff whilst residents are in hospital and most times will then liaise with the families as per their choice.

Phone discharge is as important as a written letter as you can ask questions and get a feel for a patient and his needs.

Where residents have no family, the aged care home assumes this responsibility:

95% of our residents have no family involvement due to their homeless background.

Many of our clients do not have extended family those who do we ensure are informed about relative's status and to contact hospital with any questions.

Some respondents commented that issues of family contact can be linked to the knowledge and skills of individual hospital staff who are involved with the resident:

Depends on who the community health nurse is at the time as she deals with discharges but in the most part the information is sound and referral to me made.

If there is a problem it is usually from the new doctors who don't understand the process. This is quickly rectified by the nursing staff and discharge planner.

Quite a few comments were received indicating that these issues are not a problem in their local areas:

Good reports from relatives about the local M.P.S.

Generally, families tend to have adequate information from hospital staff.

Usually family is well informed.

Families usually told of transfer.

Most families are aware. Have had a few who have stated they can't find a Doctor in the hospital.

Have not experienced any major problems in this area. Most families are given enough detail.

And one comment suggests that aged care staff accept the situation of not involving themselves in whatever relationship exists between hospitals and patients:

Difficulty to comment on this question, as the relationship is between the hospital and the resident and/or their representative. We are generally not informed about the information that is discussed between these parties.

13.7 Summary and recommendations

While around half of respondents reported problems in this area, only one third volunteered comments about the difficulties they have experienced. Most comments relate to the nature of relationships between families and aged care

services and with hospitals as well as relationships between hospitals and aged care.

Trust relationships between families and RACFs are built up over time and based on empathy, emotional and other support and the supply of information and skills coaching to help them deal with the long-term and sometimes harrowing experience of having a loved one in care.

Respondents tried to characterise the relationship they observe between families and hospital staff. Mostly they see it as a disempowering and distressing experience for families who are placed under pressure by hospital staff to quickly make life-changing decisions, or be bypassed in the decision-making process leaving them to live with the consequences. Technical details of treatment and legal requirements are not well explained to families and when they observe the basic care needs of their relative being ignored by hospital staff, they find it very upsetting.

The relationship between these few hospitals and local aged care providers appears to be plagued with difficulties arising from ethical concerns about hospital practices that over 100 respondents have encountered in different States. Contested practices include hospital staff fostering complaints to be made about aged care homes; trouble-making comments urging families to take a poor view of aged care services; creating unrealistic expectations about what aged care can offer; making disparaging remarks about aged care without being informed about the industry or giving due consideration to the harm they may be causing to families and colleagues working in aged care. On top of these poor practices, some respondents believe these few hospital clinicians use these strategies because they are covert about their own low standards and use legal hurdles to protect themselves from discovery.

13.7.1 Recommendations

Introduce a similar system of accreditation that currently applies to aged care. If outcome standards could be devised, based on hospital standards and principles of good practice as has been used in this survey, pockets of poor practice would be able to be identified and dealt with.

Support developments of alternative access to medical services. Hospital at home and outreach services from hospitals are less disruptive to older people and families. These could be extended more comprehensively into retirement villages and aged care homes while remaining the financial and medical responsibility of the State hospital sector.

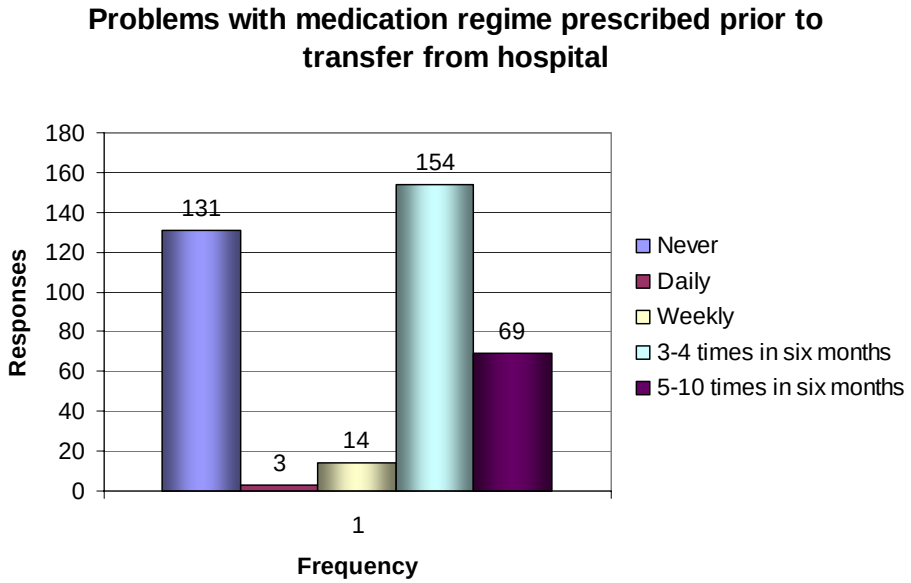
Report episodes of unethical behaviour. Many of the shoddy behaviours identified by some respondents are unscrupulous and have no place in professional practice. Instances of professional misconduct need to be reported to registering authorities and disciplinary action taken as necessary.

14 Medication regime prescribed prior to transfer to your facility

Residents are usually transferred to hospital following a serious health event requiring medical intervention and treatment. Sometimes the health crisis is rapidly resolved and residents return to the RACF with no significant changes made to their ongoing medication regime or therapy plan set up before going to hospital. Where such is not the case, and residents return with different medications and therapies prescribed, it is important to the success of medical care that continuity of treatment be maintained during and following transfer from hospital.

It is of concern therefore that respondents to this survey report that problem-free medication prescription and management occurs for only around 1:3 residents discharged to aged care homes. The graph below shows that 64.7% (n=240) of those responding to the survey have concerns in relation to various aspects of medical treatment and medications.

Overall 23% (n=86) of respondents report frequent experiences, from daily to weekly and several times a month, of problems associated with prescribed medications for residents being transferred to aged care following a hospital stay. 41.5% (n=154) indicate that problems occur every 5-6 weeks or so.



14.1 New South Wales

In NSW significant and dangerous problems appear to be associated with medication arrangements for residents returning from acute hospital stays. Aged care respondents across all locations are experiencing high levels of issues and these are frequently occurring, sometimes every week or even daily. This is a surprising result considering that NSW has performed better than other states on most of the other issue categories.

From the table shown below only two respondents out of the 100 received from NSW, claim never to have experienced problems with hospital medications linked to residents being transferred following an episode of acute care. Further, the table also shows that these incidents occur quite frequently in every location which

indicates a widespread issue affecting all aged care staff who have residents returning from hospital.

The table shows that 100% of respondents from large metropolitan centres, outer suburbs and country towns claim they experience problems with the way hospitals manage medication prescribing, reporting and arrangements for transfer.

In large regional centres this drops to 98% which is really not so much better.

NSW	***Frequency of medication regime problems***						
Location of facility		3-4 times in six months	5-10 times in six months	Weekly	Daily	Never	**Total**
A large metropolitan centre	Count	10	22	6	1	0	39
	% category	25.64	56.41	15.38	2.56	0.00	100.00
	% of Total	10.00	22.00	6.00	1.00	0.00	39.00
In a large regional centre	Count	7	6	5	0	2	20
	% category	35.00	30.00	25.00	0.00	10.00	100.00
	% of Total	7.00	6.00	5.00	0.00	2.00	20.00
In a small country town or village	Count	5	6	0	0	0	11
	% category	45.45	54.55	0.00	0.00	0.00	100.00
	% of Total	5.00	6.00	0.00	0.00	0.00	11.00
In the outer suburbs of a city	Count	8	16	6	0	0	30
	% category	26.67	53.33	20.00	0.00	0.00	100.00
	% of Total	8.00	16.00	6.00	0.00	0.00	30.00
Total	Count	30	50	17	1	2	100
	% category	30.00	50.00	17.00	1.00	2.00	100.00
	% of Total	30.00	50.00	17.00	1.00	2.00	100.00

14.2 Queensland

In Queensland respondents also experience problems with hospital management of medications for residents being transferred to aged care, however at a lesser rate than occurs in NSW.

Starting from the highest level of problems in this regard, large regional centres has 88.89% of respondents who experience problems with hospital medications for residents; outer suburban areas report 76.19%; country towns report 63.16% and large metropolitan areas report 68.42%.

QLD	***Frequency of medication regime problems***					
Location of facility		3-4 times in six months	5-10 times in six months	Daily	Never	**Total**
A large metropolitan centre	Count	9	3	1	6	19
	% category	47.37	15.79	5.26	31.58	100.00
	% of Total	10.47	3.49	1.16	6.98	22.09

In a large regional centre	Count	11	11	2	3	27
	% category	40.74	40.74	7.41	11.11	100.00
	% of Total	12.79	12.79	2.33	3.49	31.40
In a small country town or village	Count	10	2	0	7	19
	% category	52.63	10.53	0.00	36.84	100.00
	% of Total	11.63	2.33	0.00	8.14	22.09
In the outer suburbs of a city	Count	9	6	1	5	21
	% category	42.86	28.57	4.76	23.81	100.00
	% of Total	10.47	6.98	1.16	5.81	24.42
Total	Count	39	22	4	21	86
	% category	45.35	25.58	4.65	24.42	100.00
	% of Total	45.35	25.58	4.65	24.42	100.00

14.3 South Australia

From the table below South Australian respondents appear to have a much more encouraging view of the way hospitals in every location manage their medication arrangements for residents transferred to aged care following a hospital stay.

50% of respondents from country towns claim to have had no problems at all with hospital medication management for residents. Of course this means that every second respondent has experienced such difficulties. In outer suburbs 70% of respondents report experiences of problems in this aspect of resident transfer arrangements. Large metropolitan and large regional centres report problems from 63.16% and 62.50% respondents respectively.

SA	***Frequency of medication regime problems***						
Location of facility		3-4 times in six months	5-10 times in six months	Weekly	Daily	Never	**Total**
A large metropolitan centre	Count	7	4	0	1	7	19
	% category	36.84	21.05	0.00	5.26	36.84	100.00
	% of Total	15.56	8.89	0.00	2.22	15.56	42.22
In a large regional centre	Count	3	1	1	0	3	8
	% category	37.50	12.50	12.50	0.00	37.50	100.00
	% of Total	6.67	2.22	2.22	0.00	6.67	17.78
In a small country town or village	Count	2	2	0	0	4	8
	% category	25.00	25.00	0.00	0.00	50.00	100.00
	% of Total	4.44	4.44	0.00	0.00	8.89	17.78
In the outer suburbs of a city	Count	3	4	0	0	3	10
	% category	30.00	40.00	0.00	0.00	30.00	100.00
	% of Total	6.67	8.89	0.00	0.00	6.67	22.22
Total	Count	15	11	1	1	17	45
	% category	33.33	24.44	2.22	2.22	37.78	100.00
	% of Total	33.33	24.44	2.22	2.22	37.78	100.00

14.4 Victoria and Tasmania

By far the worst experiences of respondents in Victoria and Tasmania are reported from large regional centres with no respondents able to say they had never experienced any problems with the way hospitals handled medications for residents being transferred following a hospital stay.

The best experiences were had in small towns where 44% of respondents claim to have had no problems with medications. City areas, both central and suburban had similar levels of difficulty with 62.86% in large centres and 65.38% in suburban areas experiencing problems.

VIC/TAS		***Frequency of medication regime problems***					
Location of Facility		3-4 times in six months	5-10 times in six months	Weekly	Daily	Never	**Total**
A large metropolitan centre	Count	15	5	2	0	13	35
	% category	42.86	14.29	5.71	0.00	37.14	100.00
	% of Total	15.31	5.10	2.04	0.00	13.27	35.71
In a large regional centre	Count	10	1	1	0	0	12
	% category	83.33	8.33	8.33	0.00	0.00	100.00
	% of Total	10.20	1.02	1.02	0.00	0.00	12.24
In a small country town or village	Count	9	2	2	1	11	25
	% category	36.00	8.00	8.00	4.00	44.00	100.00
	% of Total	9.18	2.04	2.04	1.02	11.22	25.51
In the outer suburbs of a city	Count	13	3	1	0	9	26
	% category	50.00	11.54	3.85	0.00	34.62	100.00
	% of Total	13.27	3.06	1.02	0.00	9.18	26.53
Total	Count	47	11	6	1	33	98
	% category	47.96	11.22	6.12	1.02	33.67	100.00
	% of Total	47.96	11.22	6.12	1.02	33.67	100.00

14.5 Western Australia

Western Australia respondents from large metropolitan centres experienced more problems than not with 85.71% indicating experience of medication problems. Large regional centres generated 88.89% of respondents with difficult experiences while outer suburban areas fared much better with 54.55% claiming to have had poor experiences of the way medications were managed for residents being transferred from hospitals to aged care homes.

WA		***Frequency of medication regime problems***				
Location of Facility		3-4 times in six months	5-10 times in six months	Weekly	Never	**Total**
A large metropolitan centre	Count	14	4	0	3	21
	% category	66.67	19.05	0.00	14.29	100.00
	% of Total	33.33	9.52	0.00	7.14	50.00

In a large regional centre	Count	5	3	0	1	9
	% category	55.56	33.33	0.00	11.11	100.00
	% of Total	11.90	7.14	0.00	2.38	21.43
In a small country town or village	Count	0	0	0	1	1
	% category	0.00	0.00	0.00	100.00	100.00
	% of Total	0.00	0.00	0.00	2.38	2.38
In the outer suburbs of a city	Count	4	1	1	5	11
	% category	36.36	9.09	9.09	45.45	100.00
	% of Total	9.52	2.38	2.38	11.90	26.19
Total	Count	23	8	1	10	42
	% category	54.76	19.05	2.38	23.81	100.00
	% of Total	54.76	19.05	2.38	23.81	100.00

14.6 Qualitative themes

Of the total responses 45% (*n*=167) provided comments on issues associated with medication prescribing and management for residents returning from hospital.

Comments about medications include concerns that hospital medical staff do not understand the constraints under which aged care services operate; the practical aspects of medication supply in different localities; prescriptions not completed to satisfy legal requirements; and serious doubts about the competence of hospital staff in relation to organising and managing discharges for older people.

Some respondents shared strategies used to address issues of misunderstanding, legal non-compliance and management incompetence in relation to safe discharge of residents with medical treatment back to RACFs.

14.6.1 Little or no problems experienced

Only 8% (*n*=13) of the comments received report few if any problems in this area. A selection of comments for this group is shown below:

> *This has occurred but not in last 12 months usually a transcribing error.*
>
> *No problem. LMOs are aware of need to attend to this area personally.*
>
> *Generally it is good and well planned for new admissions - but not transfers.*
>
> *This has not been an area of concern to us due to the good working relationship with the resident's GP and Pharmacy.*
>
> *Generally o.k. Would like to know the reason for change of medication though.*
>
> *Sometimes the hospital staff are very good at discussing medication changes with facility staff other times meds are changed without notification.*
>
> *Generally, this aspect of acute care hospital discharge is satisfactory.*

14.6.2 Understanding of aged care operational constraints

Skilled prescribing and administration of medicines has great potential for enhancing the quality of life for older people. When problems arise in terms of supply and administration of medicines, the health and wellbeing of individuals relying on medical and other staff to provide care can be compromised. It is important therefore that differences in care environments be well understood so

that realistic protocols and processes are implemented to service residents transferring from hospitals to residential aged care environments.

The differences between hospitals and aged care are clearly not understood by hospital personnel. Poor understanding by hospital doctors and nurses of the differences and constraints under which different aged care services function becomes quite concerning when it cannot incorporate the different medication management and administrative systems used in high and low care facilities. Low care facilities with less dependent residents are unlikely to have registered nurses or medication endorsed enrolled nurses employed there. These facilities rely on medication distribution systems that place the burden of responsibility on prescribing doctors and pharmacists supplying the medications in a system able to be managed by trained care staff.

> *Hospital tend to have Registered Nurses administer the medications from bottles, in most residential facilities you have untrained staff administering from pre packed cards done by an external Pharmacist. Often not enough medications to tide over until can get Pharmacist to do up pack and/or come to the facility too late to get Pharmacist to prepare meds.*
>
> *Often the medications are changed and the resident is sent back late in the day and it is not possible to get a doctor in to write up the medications. All our medications are packed in Webster packs and can only be administered by credentialed staff from the Webster packs.*
>
> *Aged care facilities have very strict medication systems in place and require transferred medication to be packed in Webster or other medication systems, which could not be provided from hospitals.*
>
> *We always have to advise acute care that staff cannot administer medications from boxes. Advised to contact our pharmacy or forward the chart to us so we can get our pharmacy to make up the medico packs in preparation for their return to site.*

Sometimes medications are ceased at hospital discharge and new prescribed medications prescribed as follow-up arrangements:

> *Often resident is placed on regular analgesia when in hospital – this is ceased on day of discharge. Our resident will be commenced on new medication on day of discharge.*
>
> *Often facility is not notified of medication changes.*

Discontinuity of care in what is assumed to be significant medical treatment occurs because of poor timing of discharges; inadequate planning around medication supplies and administration systems; and lack of consultation with the referring medical practitioner who provides ongoing medical care to the resident:

> *Use of sedation, psychotropic meds whilst in hospital makes care provision difficult on return. Conversely stopping existing medications for behaviour management, pain management or bowel management whilst in hospital also can pose issues on return. Commencing medications in hospital requiring authority scripts can make it difficult to supply on return, particularly if information regarding eligibility for authority script is not provided also, can result in high costs of provision without authority, or discontinuing meds on return.*
>
> *Arriving late on a Friday, with no scripts, no meds and changes from what we sent them to hosp with. Hospital in the home has helped with this issue. Changes in meds with no reason given as to why.*
>
> *Often there is no transfer information. What medical regimes. Acute care doctors often change medication and on arrival back to the facility the persons chosen GP will again change the medication.*
>
> *No recognition of the fact we may not be able to get G.P. to review and write up immediately-however this is now improving and some hospitals are sending us copies of drug chart we can use for a few days.*

The hospital does not always communicate changes to medications to the GPs in a timely manner and there is sometimes confusion regarding current medications and what changes have occurred during the acute episode.

We only deal with Webster Packs & sometimes the hospitals don't even send us any medication information. Hospital changes medications without discussing with regular G.P. & then G.P. changes it back - we have no idea why sometimes & who is to say which is appropriate.

14.6.3 Medication supply issues

Even if the prescription and recommendation of a suitable medication distribution system is in place when a resident is discharged, problems may still occur in accessing supplies of medication and in suitable packaging. No doubt the same problems confronting aged care homes in overcoming supply issues will be experienced by families returning to their own homes from hospital:

Hospital refused to send enough meds to cover until facility doctor's next visit. Medical staff do not understand our medication regime. No communication of a handover as hand writing is appalling. Staff in hospitals get very terse if facility staff ring to confirm orders.

Major, major areas of concern! Aged care facilities have different format/charts and do not have access to pharmacy outside business hours.

Sometimes residents prescribed medication in hospital which is not immediately available in retail chemists.

Difficult to get medication information before receiving resident back to facility. This makes it difficult when Websters have to be packed by pharmacy prior to resident returning.

If changes have been made and a resident is returned out of hours or on weekends, it is difficult to get these changes reflected in medication packs for up to a couple of days.

We use a Webster system to dispense medications therefore have no pharmacy on site. Drugs are often not supplied for enough days to allow the drugs to be Webstered because they have not taken on board the information we have conveyed pre admission.

This usually relates to people being sent back just prior to or on the weekend when the pharmacy is shut and we are unable to access Webster changes.

No medication charts sent with the returning resident. Residents returned late Friday or on the weekend when difficult to get doctors to write charts up or pharmacy not available.

Not enough information. Often transferred on Friday pm without medications which poses difficulties in obtaining medications from pharmacies after hours.

Very difficult to continue a prescribed medication regime when residents are transferred back over the weekends as GP will not call to amend drug charts etc and pharmacy hours are even more limited.

Some S8s are not sent for palliative residents and no discharge letter to give us up to date medication orders to follow.

The quality of medications and medication prescriptions also affects supply once residents have returned to aged care:

Medication info often out of date, poorly presented info, regularly no supply of interim medication on discharge.

Frequently no information on changes made and reasons why. Too much medication supplied which cannot be repacked into sachets by our local pharmacy. Again public hospitals are working through local Division of GPs to improve situation but private hospitals are a big problem.

> *Sometimes regime changed but no scripts accompanying. This is hard to chase up with pharmacy who require scripts.*

The issue of who pays for medications is also a supply concern. In aged care residents pay for their medications and these need to be in a form that can be administered safely within the aged care context. Often this is not understood by hospital doctors who write the prescriptions:

> *Often come back with double the medication they left with. Other issue is that the hospital prescribes expensive medication for residents whilst in hospital that they can NOT afford when they are discharged.*
>
> *Only issue has been hospital's now charging for discharge medications and providing them in a form that we cannot use.*
>
> *If discharge summary is not sent then we are unaware of changes. Hospital scripts cannot be cashed at our chemist.*

The location of the aged care home has some effect on availability of pharmacy services. Again, it seems from respondents' comments that hospital staff do not always appreciate difficulties associated with accessing supplies of medicines on the weekend or after business hours:

> *Staff have needed to liaise with hospital and pharmacy to ensure prescribed medication is made available e.g. when a small amount of medication not sent and there it is difficult to communicate with the pharmacy that services the facility e.g. out of normal hours.*
>
> *Medication not forwarded with resident over weekend and town has no pharmacy. Scripts and medication sheets not forwarded. Unclear if meds given.*
>
> *Changes to medication regimes are usually sent to the GP and not to the facility. This means time spent in chasing any relevant changes.*
>
> *Often insufficient medications are sent, or the pharmacy discharge does not match the medical discharge.*
>
> *The resident is often transferred without adequate supply of medication - they forget to forward prescription worse if this is a Friday/ public holiday discharged client.*

14.6.4 Legal issues in medical prescribing

Legal requirements seem not always to be considered by hospital staff when they discharge people who need ongoing prescribed medications. Delays in satisfying basic legislative requirements for managing prescribed medications can result in serious disruption to medical treatment:

> *Ongoing problem in low care facilities, acute hospitals will send a resident back to a facility at 4pm, with a box of antibiotics etc, this cannot be administered by care staff in a low level care facility, or the discharge summary will only state please change a particular med. This one is a constant issue!!!!*
>
> *It is not the prescribing of the medication; it is the problem of getting a doctor to sign the order from the hospital. Sometimes medication is changed and it may be some time before the resident is seen by the treating GP.*
>
> *Low care facility unable to administer medications unless prescribed - hospital does changes and lets pharmacy know but does not give facility medication chart.*
>
> *We have trouble getting follow-up scripts.*
>
> *Medication is an issue in so far as the Doctors are usually uncontactable after hours, especially the specialists.*
>
> *Medication Charts not received - usually only a list is received, but staff unable to administer from 'a list' - nowhere to sign for administration.*

> *An ambulance officer passed on an order to increase a dose of a resident's medication - there was no written order from a Medical Officer. The order had to be chased up by nursing home staff.*

Safe prescribing practices by hospital doctors seem also be a concern for several respondents:

> *Doctors really know very little about medications for very elderly and/or palliative care cases.*
>
> *Every time there is no explanation why the meds are changed, and the GP is asking why. Continuity of pain regimes is a difficult area but transferring someone on a narcotic for 10 days including immediately prior to the transfer, then writing up discharge meds with Panadol QID send pressure on the N/Home staff to convince a locum that the undocumented meds were 1) being given and 2) needed. If we fail then the resident is in pain.*
>
> *Different medications ordered on med charts to discharge advice. Different medications faxed to pharmacy and to nursing home.*
>
> *Medications aren't correctly written up and Websters or medications dispensed are not done so correctly.*
>
> *Residents not being prescribed all their medication due transcription errors.*

Respondent concerns also extend to problems with accessing legally valid prescriptions following hospital discharge:

> *Often not written clearly for us to read. Not always accurate.*
>
> *Incomplete orders, inadequate orders, no medication chart on an after-hours transfer, illegible orders.*
>
> *Medication charts incomplete or not signed by doctor.*
>
> *Inaccurate directions often as a result of multiple variations in the same medication order.*
>
> *Medication orders unclear or conflicting with prescriptions to pharmacy.*
>
> *Medication problems we encounter include: Schedule 8 medications not being handed over properly in accordance with current legislation. There is regularly a problem with 4/5 returns/admissions from hospital where resident's medication has changed dramatically, they return after 4 or 5 in the afternoon, the GP is unable to make it to the facility, a locum has to be called, the locum doesn't visit until later that night (usually after 12), then an RN who wasn't on duty when the resident arrived from hospital has to catch the locum up on the medication changes.*

Follow-up strategies in ensuring prescriptions are legal can be made more difficult because of difficulties in accessing medical practitioners able to come to the aged care home and sometimes, no communication has been received from hospital doctors pertaining to medication changes or why these have occurred:

> *Resident medications are sent to the pharmacy and blisters are repacked but medication charts aren't updated and it is often hard to gather GP to come in and write up the altered routine.*
>
> *If the regime is not communicated it is often not possible for the facility to continue this regime legally as they have no signed orders for the new regime until a Dr visits.*
>
> *Difficulty in accessing Acute Drug Chart to use until GP can visit to write up any changes. We are not notified of medication changes prior to transfer, although instant update goes electronically to GP and Community Pharmacist.*
>
> *This is the most frequent problem experienced. Drug charts are often not complete or there is not enough time available for the signing of the administration of medications particularly if there is a delay when the resident's GP can visit to update the resident's drug chart at the facility.*

Medication regimes often differ to the resident's GP. This is an issue because there is often no correspondence related to meds to the GP.

14.6.5 Competence concerns

Staff working and practising in aged care services are in a position to observe the practices of hospitals in relation to the care of older frail residents who need to seek acute medical treatment services. It follows that they will come to a view about the competence of hospital staff in relation to quality and safety of hospital services. In this section, the views of many respondents suggest that they have observed and evaluated medical practices in the course of their dealings with hospitals.

Many of these issues are encapsulated in the comment below:

We continually provide the hospital with medication charts and labels used by our facility in medication management. However I have seen them used on one occasion only in the last six months. Medications changes are made and no order is provided to allow for its administration. This is particularly hard when commenced on antibiotics and we have no order. It then uses valuable time and resources chasing up staff to provide these. Once resident is discharged from hospital their staff want no further involvement.

Further concerns have been expressed about approaches taken by hospital doctors in altering medication regimes for residents without consultation with referring general practitioners and also with no notification of medication changes to either the general practitioner or aged care nurses:

Would be good if Dr could liaise with the GP and arrange for any changes that need to be made, so that the GP will know why it was changed, often no information comes with the changes and GP just go back to previous medication. Would be great if hospital could send some medication for at least two days until we can arrange from our pharmacy.

Complete changes of medications with little documentation of rhyme or reason for the changes, causing anxiety with the resident family and staff let alone the GP, or often the locum service.

Medications are ALWAYS changed when in hospital.

Medications ceased prior to discharge, written on discharge summary and not altered before transfer.

Due to the nature of the discharge summary (incapable of being read) GP is often not totally clear on what medications were prescribed by the hospital staff.

Medications often changed, altered or added to at the hospital, without consultation with the residents' GP.

Medication changes with no apparent reason documented.

Medication has been changed without referral to resident's usual doctor.

Other comments suggest that hospital doctors seem to find it difficult to work in a team-approach involving non-hospital staff, even though this could ensure continuity of care and treatment for residents of aged care homes:

Often medication changes are not made known to staff before clients return from hospital. Often our pharmacy provider is not contacted when we are told there will be changes and often staff are not told that they require a GP to make changes to the client's medications.

Medications have been changed with no scripts forthcoming. Residents sent back without medications to keep them going until new script arrives. No instructions on how to utilise medication.

Often medications are changed in hospital, requiring local GP and pharmacy to have to chase up sachets for change and med chart changes at facility. Often no documented reasons for the changes.

Medications left back at the hospital. No medications coming with the resident. Transfer letters stating medications illegible.

Medications changed - no consultation on getting new Webster packs no new medications charts, no scripts for pharmacist.

Often no orders, no medication or changes not updated. Has required GP to come up when it could have been avoided if it was correct from the hospital.

Constant problem. No communication between referring agency and treating medical officer. Hence, orders are not carried out accordingly.

Even when we have contacted the Hospital and asked them to either fax us or the Pharmacy the ordered medications to be made up etc. We find it is not done so time is wasted getting medications made up according to our Facilities policy e.g. Sachet system.

For some medications, processes around administration directly relate to issues of safety and effectiveness of medical regimes. Some concerns were expressed at the dismissive approach taken by some hospital doctors in ensuring that prescribed medicines are administered appropriately following discharge:

Residents not set up for Warfarin Dosages and INR levels unclear instructions.

Resident transferred to low care. Discharged on antibiotics - no medication supplied, no script supplied.

Not all regular medications prescribed or dosages changed inappropriately, no time of meds last given on chart/transfer form, some meds missing from discharge pack, medication supplied out of date.

Unnecessary use of clexane, fosamax, insulin etc when non-injectables could be used.

Residents prescribed antibiotics (oral) for residents with difficulty swallowing. Not able to decipher orders.

Safety and quality requirements in prescribing and administration of medications is impossible to achieve when communication around the medication system is not understood by those responsible for administering it. Selected comments on these issues are shown below:

Even the pharmacist did not understand the order.

Medication d/c documentation does not match medication. Medication ceased in hospital not appearing as 'ceased on discharge' docs. Therefore need to check that it hasn't just been forgotten.

Medication charts not completed by Dr. No prescriptions. Hospital and doctors in adjacent towns.

Regimes not clearly written. At times stated "as prior to admission" and then staff have realised changes were made.

Not able to read Doctor's written orders.

Medication orders not written up.

Not sure if medication not continued - whether it is ceased or just forgotten to list.

Discrepancies in medication order forms and discharge letters.

This is often not clear and medications arrive that do not correlate with written instruction or on what resident says they are taking.

No medication orders with resident.

No information sent, no name of contact person.

Individual medication not written up Medication charts not done.

Medication regime is not passed on other than what the resident comes back with from pharmacy which is usually in a bottle or few tablets in a packet. No medication or discharge information is given on many occasions.

Often transferred with no new medication chart.

New medication not sent with resident on discharge. Not informed of drug changes, despite room on discharge form for such information.

Medication changes no conveyed to facility or Facility pharmacy not advised.

14.6.6 Strategies

Some respondents provided examples of strategies they use to overcome dangers they believe are associated with hospital medical practice. In some instances there is a need for aged care staff to make direct contact with hospitals to validate prescriptions so that they can be confident of the accuracy and legality of the order:

Almost every transfer from an acute hospital setting has required us to clarify drug orders.

It has become common practice at our facility to ask hospital staff if there are any changes to residents' medications and check through with them over the phone. If there have been changes the hospital is now cooperating in forwarding changes to our pharmacy to enable us to get new medication sent on the day of discharge.

This is important, and again we need to follow up with the discharging person at the hospital to obtain correct information.

We communicate with the charge nurse prior to discharge to discuss ongoing treatments and ensure pain management is followed through. Only a problem if someone new is on and does not let us know a resident is coming back.

Often - there is no information to us or the pharmacy. We have to make the effort to get in first to direct the discharge.

Nil issues usually contacted prior by hospital pharmacy department they often Webster pack medications or liaise with our contracted pharmacy to have medications packed.

It is often difficult to get an accurate picture of the resident's current medication. We often need to ring the hospital and go through the maze of Drs to determine the right medication.

Often have to ring and ask for medication discharge letter.

Facility anticipates problems and liaises with staff/medical practitioner prior to transfer - especially with pre-term medication profile and 48hr tablets.

Another area of aged care initiated action is to facilitate communication between treating medical practitioners to increase the possibility of their reaching agreement on medical treatment prescribed:

This is getting better, but it is still a nightmare. Even if the hospital pharmacy faxes to our pharmacy (which is good liaison work) you then have the added problem of the treating GP in the home not agreeing to any changes until he has reviewed the resident - which could be ??? SO this complicates the medication regime. It would be best if the hospital doctor liaised by phone with the treating GP to ensure all medications were streamlined. Then there would be no problems in the home or with the ACF's pharmacy or with the GP.

General practitioner often does not agree with medication alterations - hence we always fax GP with hospital recommendations for approval prior to commencing resident on changes.

We have had to put a policy in place that residents' GPs are to approve any medication regime prescribed by hospital staff due to anomalies in original medication and discharge medication. Pharmacy has refused to pack blisters off discharge summary.

Perhaps not this often -usually when the hospital doctor has treated resident (public patient). The private doctors in the most part are

exceptional. If we have concerns we will discuss medication regime with the off-site clinical pharmacologist then approach the doctor if necessary. Often the transfer medication form is not written up and so it goes back to the residents preferred doctor to write prescription in drug chart. Changes often occur at this time.

Comments were also received in relation to facilitating communication between medical, pharmacy and aged care staff so that all involved in the care team understand what is happening in relation to residents' medications:

The hosp. pharmacy lets the resident pharmacy know of what changes that have occurred. This breaks down at times if there seems to be rush to get the resident out of hospital. E.g. when the weekend is coming up.

This is a minor problem as the hospital pharmacies make direct contact with the home pharmacy. It is a problem if the GP is unable to come to the home to re-write the medication orders. This is exacerbated by poor discharge information to the home staff or conflicting written information to the staff and the GP, as happens.

"Yellow envelope" sent with form for changes to medications to be written up as a legal order - much improved. Looking into getting discharge meds from NH's regular pharmacy before discharge from hospital.

Medication chart is faxed to pharmacy for packing.

It is clear from comments received that some aged care providers have formed collaborative links with nearby hospitals in an effort to improve quality and safety of cross-sectoral medication management systems:

This has been a major past issue for us, which we now seem to have addressed through the action groups work. We now get a prewritten discharge medication administration form, so we can continue to administer discharge drugs until GP or Locum can take over which may be 2-3 days later, or more. We also receive a much better pharmacy discharge summary in the medical discharge letter. However this is only improved in relation to one specific acute centre who have taken the initiative to work with us to improve continuity and quality of care for the transferring resident, and consider the resource issues for RACFs.

Private hospital is good at providing copy of current medication orders and arranging new Webster packs etc. Public hospitals often do not provide orders until you have rung up to remind and then will fax them - take up to 36 hrs - also often don't arrange pack changes.

Local public and private hospitals have copies of our medication charts and it is part of their discharge package. We also double check to ensure it is all organised prior to discharge.

The facility provides medication charts at the local hospital, with detailed instructions for use but they continue to write up medications in the wrong chart.

14.7 Summary and recommendations

Of all the problem categories covered in this report, medication issues relate directly to the credibility and competence of hospital medical staff. With so many respondents identifying this as a major problem for residents and families and for them as they attempt to take over resident medical care, it is important to think about the extent of the problem and what may be causing it to occur.

It is clear that many doctors do not understand the aged care industry, its services, how it is set up, funded and accredited. Many of the problems arising from medical mismanagement of prescribed drugs for the aged care context may well relate to a lack of interest shown by many doctors in aged care. For instance, by not understanding the operational constraints of aged care, prescriptions that may be acceptable in hospitals become invalid out in the community where they need to be filled. Some respondents have commented on an apparent reluctance

of some hospital doctors to get involved with non-hospital personnel in devising and planning care.

Supply issues also relate to medical lack of information about timing of discharges so that pharmacy supplies are available; or understanding who pays for the drugs under certain circumstances decided by the prescribing doctor. Safe prescribing is also an issue when changes are not explained to the general practitioner taking over the case; or where medication orders are illegibly written and inconsistent within the same documentation. The form of drug prescribed can also be unrealistic in an aged care home where there is no registered nurse to perform the procedure and monitor for adverse effects and reactions.

14.7.1 Recommendation

Facilitate communication between doctors and pharmacists. Some effort is needed by aged care staff to bring these episodic care providers together on issues of safety and quality. Medical Advisory Committees could be one option but a similar effort is needed to ensure hospital quality and safety concerns are voiced and remedied.

Formal collaborative links between hospitals and aged care. A formal mechanism is needed for reporting medication prescribing errors and to follow-up on inconsistencies in medical orders.

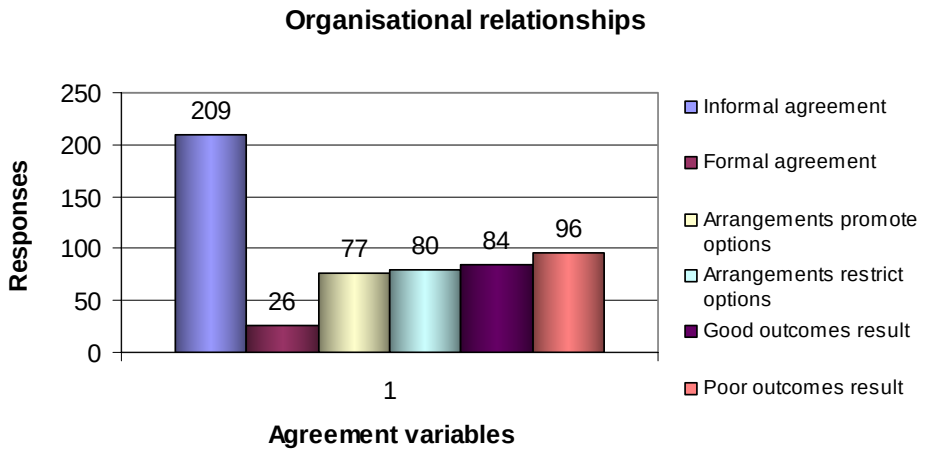
15 Respondent perceptions of operational relationships

As the majority of respondents are directors, managers and executive officers who are well aware of matters covered in any agreement, either formal or informal, between the RACF and local hospitals. Therefore when 56.33% state that they have an informal agreement in place it is likely to be based on discussions between the organisations in relation to resident transfers. Only 6% of all respondents said they have a formal agreement in place with the hospital sector and 62.4% of respondents have some sort of agreement operating. Still, 21% claim that the arrangement restricts options for sharing information and skills, and 25.88% report that the current relationship between the RACF and the local hospital leads to poor outcomes for residents.

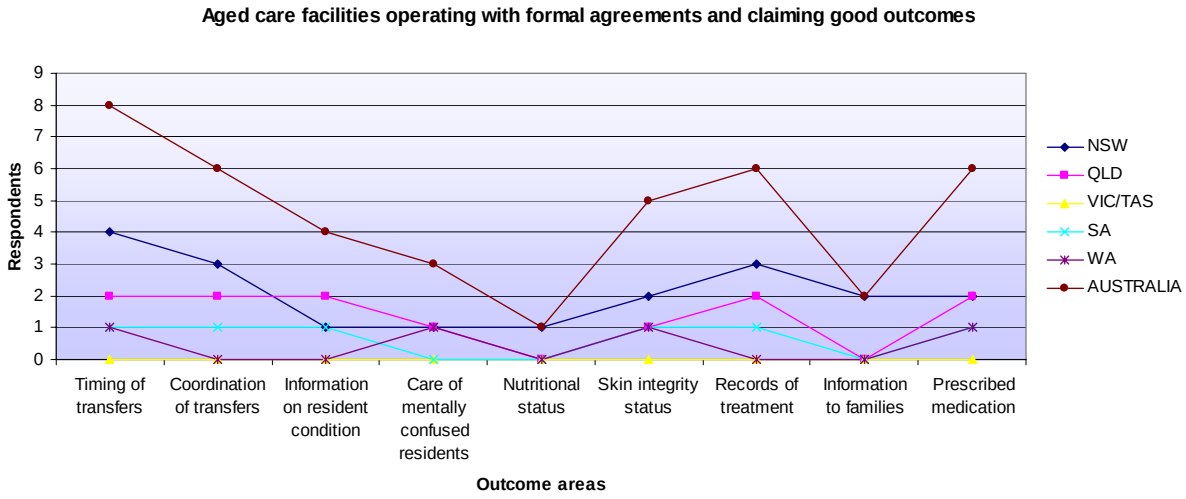
Table 17 Hospital and aged care operational relationships

Interagency relationship variables	Responses	%
We have an informal agreement about resident care and services including transfers to and from hospital	209	56.33
We have a formal agreement in place to cover mutual expectations about resident care and services including transfers to and from hospital	24	6.46
The formal agreement between our facility and local hospitals is long-standing (over 2 years)	18	4.85
The formal agreement between our facility and local hospitals is quite recent (under 2 years)	8	2.16
Existing arrangements between our facility and local hospitals promotes information and skill sharing between both staff groups	77	20.75
Existing arrangements between our facility and local hospitals restricts opportunities for staff to share information and skills	80	21.56
Existing arrangements between our facility and local hospitals results in good outcomes for residents who transfer between services	84	22.64
Existing arrangements between our facility and local hospitals results in poor outcomes for residents who transfer between service	96	25.88

Total Answers: 596 (Allows for multiple answer selection)



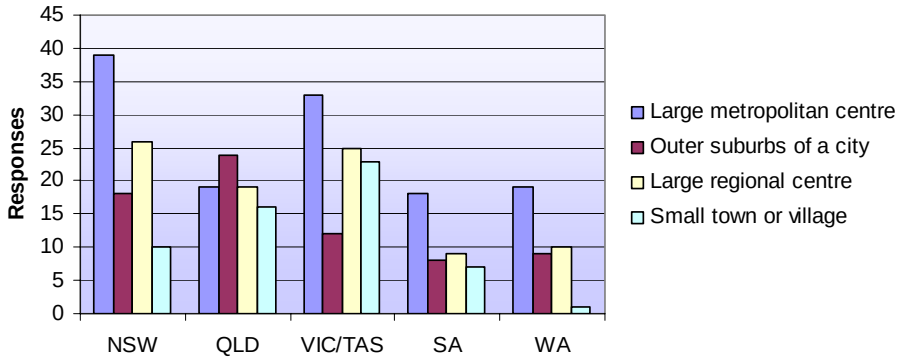
The small group of 24 (including the two respondents who had both formal and informal agreements) respondents who claim to have formal agreements in place with local hospitals seem to have somewhat different patterns of issues in relation to resident transfers however some problem areas (timing of transfers; documentation of treatment received) seem to persist despite having a formal agreement.



15.1 Issues arising with formal and informal agreements

The group with formal agreements in place do not indicate the nature and extent of agreements and whether issues arising from resident transfers are actually covered. Because several problem areas remain for this group, it is likely that existing agreements are more concerned with matters other than resident transfers or clinical outcomes. The graph below shows the spread of RACFs operating without formal agreements with local hospitals.

Aged care facilities operating without a formal agreement with local hospitals



In terms of advantages that seem to occur with formal agreements in place, the table below shows that those who think they have informal agreements with hospitals experience higher levels of problems than other respondents in all but one of the problems categories. Ironically the small group with formal agreements also have problems with timing of transfers and medication management.

Even so, respondents with formal agreements report better outcomes in areas of resident condition information; care of mentally confused residents; and documentation on acute care given to residents.

In terms of each of these broad outcome areas it is interesting to drill down into the data to see the spread of experiences in relation to the type of arrangements respondents have in place. The table below shows each problem categories in relation to the presence or absence of agreements between hospitals and RACFs, and also those who claim to have no agreement. The frequency of problems with timing seems to be prominent for respondents who say they have an informal agreement in place with the next largest being those with no agreement at all. The two respondents who claimed to have both formal and informal agreements in place are not included in the table below.

Problem area:	Agree-ment type:	% respondents reporting problems	3-4 times in six mths	5-10 times in six mths	Weekly	Daily	Never	Total (% total)
Transfer timing	None	77.14%	76	28	3	1	32	140 (37.7%)
	Informal	84.39%	128	30	14	1	32	205 (55.3%)
	Formal	95.45%	15	6	0	0	1	22 (5.9%)
Transfer coordination	None	51.42%	60	21	1	2	56	140 (37.7%)
	Informal	68.87%	108	22	11	0	64	205 (55.3%)
	Formal	63.63%	9	5	0	0	8	22 (5.9%)
Resident condition information	None	77.85%	71	33	5	2	29	140 (37.7%)
	Informal	79.02%	115	40	7	0	43	205 (55.3%)
	Formal	63.63%	10	6	0	0	6	22 (5.9%)

Mentally confused residents	None	43.57%	50	10	1	2	77	140 (37.7%)
	Informal	53.17%	84	19	6	1	95	205 (55.3%)
	Formal	40.91%	9	0	0	0	13	22 (5.9%)
Resident nutritional status	None	31.42%	36	6	2	2	94	140 (37.7%)
	Informal	42.43%	73	11	3	0	118	205 (55.3%)
	Formal	40.90%	5	4	0	0	13	22 (5.9%)
Resident skin integrity	None	60.00%	68	14	2	3	53	140 (37.7%)
	Informal	76.58%	119	33	5	0	48	205 (55.3%)
	Formal	63.63%	11	3	0	0	8	22 (5.9%)
Reports on acute care provided	None	76.42%	68	33	6	2	31	140 (37.7%)
	Informal	85.36%	123	42	10	0	30	205 (55.3%)
	Formal	72.72%	12	4	0	0	6	22 (5.9%)
Information provided to families	None	47.14%	47	15	4	2	72	140 (37.7%)
	Informal	56.58%	89	22	5	0	89	205 (55.3%)
	Formal	54.54%	6	6	0	0	10	22 (5.9%
Medication issues	None	62.85%	59	27	2	2	50	140 (37.7%)
	Informal	64.87%	84	37	12	1	71	205 (55.3%)
	Formal	68.18%	10	5	0	0	7	22 (5.9%

The contents of existing agreements are not clearly understood and it is possible that these agreements do not clearly state what is expected in terms of performance targets related to continuity of care and service coordination; or outcomes for residents transferring between services.

A broad range of standard elements contained in memoranda of understanding between services was used in the survey to gauge the content of existing agreements. Details of these elements and the survey results are contained in the sections below.

16 Inter-organisational agreement elements

While acknowledging that agreements between organisations can be both formal and informal certain elements are recommended for inclusion in such agreements by the Australian Health Ministers' Advisory Council (AHMAC) report from its working party, entitled "*Age-friendly principles and practices: managing older people in the health service environment".*

These elements include but are not limited to the following:

1. Type and breadth of services to be provided by the hospital in relation to resident transfers

2. Clear assignment of organisational and/or professional responsibility for the safety and well-being of residents during transfer processes

3. Timeframes and processes for client transfers

4. Waiting lists and resource constraints that might impact on service availability and continuation

5. Contact point and person for each service involved in the transfer

6. Documentation to be transferred in relation to the resident's immediate and ongoing needs

7. Client information security and ownership of records

8. Costs related to resident care and treatment initiated by the hospital

9. Sharing of professional aged care expertise with hospital personnel

Survey respondents were invited to indicate whether their agreements include these elements and results indicate that the largest concern covered by agreements (formal and informal) pertains to documentation. These results are shown in the graph and table below.

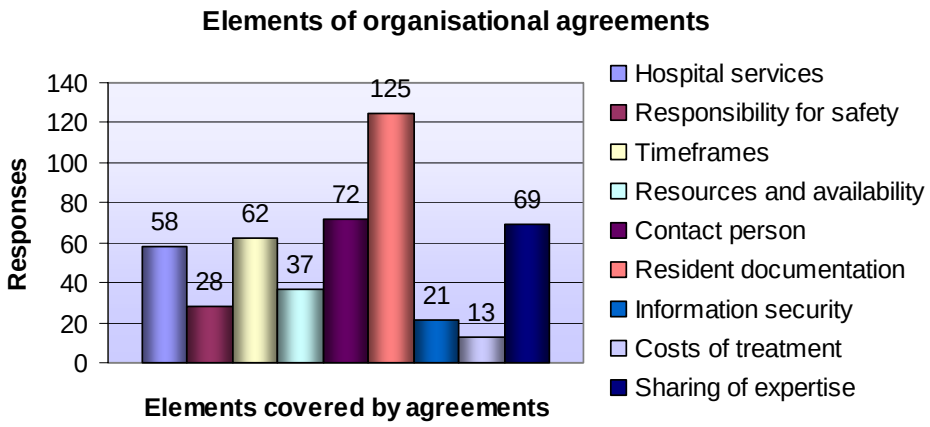


Table 18 Elements of agreement between RACFs and Hospitals

	Response	%
Type and breadth of services to be provided by the hospital in relation to resident transfers	58	15.63
Clear assignment of organisational and/or professional responsibility for safety / well-being of residents during transfer processes	28	7.55
Timeframes and processes for client transfers	62	16.71
Waiting lists, resource constraints that might impact on service availability and continuation	37	9.97
Contact point and person for each service involved in the transfer	72	19.41
Documentation to be transferred in relation to residents' immediate and ongoing needs	125	33.69
Client information security and ownership of records	21	5.66
Costs related to resident care and treatment initiated by the hospital	13	3.5
Sharing of professional aged care expertise with hospital personnel	69	18.6

(Allows for multiple answer selection)

The most commonly reported point of agreement is that of responsibility for documentation related to resident care and treatment with 33.7% of respondents claiming this as part of their agreements.

The next point of agreement (19.4%) is the establishment of a contact person in both organisations involved in residents' transfers, followed closely by agreements to share professional aged care expertise (18.6%).

Ironically, elements that may go some way towards resolving many problems identified during resident transfers are not given priority in whatever agreements are in place. For instance, costs associated with resident treatments occur in only 3.5% of responses, while ensuring that privacy and security of resident records attracts only 5.7%. Timing of transfers is mentioned by only 16.7% and resource constraints related to resident care and support is mentioned by just under 10% of respondents. 7.55% included responsibility for resident safety and well-being in their agreements yet this topic is a major cause of concern for many respondents.

16.1 Summary and recommendations

There is no guarantee that agreements either formal or informal, on outcomes or targets, will improve quality and safety for residents. However the feedback received in this survey indicates that having no agreement at all does leave the situation open to problems that may not be identified or resolved as quickly as when an agreed position has been reached on key issues.

It is possible for organisations working toward similar goals in care and service and for a similar clientele, to reach agreement on processes and protocols that can be monitored and reviewed.

16.1.1 Recommendation

Establish formal agreements between RACFs and hospitals. The template recommended by AHMAC could be used as a starting point for discussion and the issues identified through this survey could contribute to setting up outcome targets as well as mechanisms for close liaison and quality improvement.

Improve system transparency. More transparent and accountable protocols and policies need to be constructed around the joint interests of hospitals and RACFs as they work towards safer and more effective ways to transfer residents to and from services.

Cost-sharing arrangements. Investigate the possibility of sharing costs associated with assisting hospitals to improve their quality systems. Once a system is set up to acknowledge and compensate for expenditure associated with the care partnership, factors such as who pays for iatrogenic and nosocomial health costs for residents can be considered.

17 Respondent evaluation of hospital services received by residents

Aged Care services are funded and regulated primarily through the Australian Government via the Aged Care Act 1977 and Quality Principles (as amended). For the most part, hospitals are funded at State level from funds allocated for that purpose from the Department of Health and Ageing in Canberra.

The aged care industry has embraced widespread changes since the introduction of the Aged Care Act, particularly in relation to meeting quality standards for all aspects of service as a requirement for accreditation conducted by the Aged Care Standards and Accreditation Agency. These far reaching changes have moved the focus of aged care providers to achieving outcomes rather than focusing just on processes involved in delivery of care and other services. As a result of these changes, aged care managers and staff understand the role of standards, key principles and statements of best practice in guiding the approaches of staff in their everyday work.

For the purposes of this survey, three statements related to the acute hospital system and release years earlier, were chosen as a basis for comparison against observed hospital practice. Aged care personnel were provided with the statements of principle, best practice and care outcomes and asked to indicate whether they had observed these standards of hospital performance in operation.

17.1 Summary of documents used as a basis for the survey

In July 2004 the Australian Health Ministers' Advisory Council (AHMAC) received a report from its working party, entitled "*Age-friendly principles and practices: managing older people in the health service environment".* It contained a blueprint for the implementation of age-friendly principles throughout the public health-care system. Briefly these were:

1. Health treatment and care delivered to older people will be based on strong evidence and have a focus on maintaining, improving and preventing deterioration in their health and quality of life.
2. Health services will recognise and address older people's complex needs.
3. Health treatment and care are respectful and recognise individual differences and specific needs, e.g. cultural, religious sexual.
4. Health treatment and care are delivered in a coordinated and timely manner across care settings.
5. Unnecessary admission to hospital and extended hospital stays of the frail elderly are avoided.
6. The care of older people is a primary focus for all health services
7. Where safe and cost-effective to do so, older people receive health treatment and care in a setting that best meets their needs and preferences.

In that report the working party recommended 'robust protocols and agreements' be set up between all service providers in relation to:

- Type and breadth of services to be provided
- Clear assignment of responsibility
- Timeframe and process for client transfer
- Waiting lists and resource constraints which might impact on service continuation
- Contact point for each service

It was also recommended that agreed protocols be in place in the areas of:

- Client information to be transferred between providers
- Processes of information transfer
- Transfer of pre-admission information
- Timeframes for transferring discharge information
- Information security and ownership
- Common fee structure.

The working party recommended further protocols be set up between services on the following:

- A clear outline of information required by the health service – and the RACF
- Communication of health updates between service providers
- Clinical pathways to be used by RACF staff under GP supervision and hospital medical staff
- Training of RACF staff in common simple procedures.

Also in November 2004, a report from the Clinical Epidemiology and Health Services Unit, Melbourne Health, was presented to the Australian Health Ministers' Advisory Council entitled, "*Best practice approaches to minimise functional decline in the older person across the acute, sub-acute and residential aged care settings".* This report detailed work undertaken by Melbourne Health to focus on intervention and management strategies to prevent functional decline of hospitalised older people in relation to cognition and emotional health; mobility, vigour and self-care; continence; nutrition and skin integrity.

Chief among the outcomes of this report is a set of guidelines for hospital staff in relation to achieving best practice in the care of older people in hospitals and during transfers between hospital and other services. The guidelines were developed to prompt hospital staff to:

1. provide older people with healthcare that is person-centred and evidence-based
2. ensure the best possible health outcomes for older people
3. improve the function and quality of life of older people in acute, sub-acute and residential aged care.

The Australian Health Ministers' Advisory Council – Care of Older Australians Working party presented their report in July 2004, entitled ***"****From hospital to home: improving care outcomes for older people – a national action plan for improving the care of older people across the acute-aged care continuum 2004-2008".* This report was distributed throughout the public health care system as part of implementing the national plan for action on these issues.

Assumptions underlying the National Action Plan were as follows:

1. Heath and aged care systems operate to deliver a continuum of care that ensures that older people remain independent and in their usual place of residents for as long as possible
2. Health and aged care services attach greater importance to the needs of older people including culturally appropriate and accessible services for Aboriginal and Torres Strait Islander people and people with culturally and linguistically diverse needs
3. Service and support options available for older people are in line with their multiple and specific needs (e.g. dementia) as these change over time – program boundaries are less important than the older person's needs

4. Older people have access to a range of integrated services that allow them to move across the acute-aged care-community care continuum easily

5. Participation of the individual is central to the care planning processes as far as is possible

6. Informal carers and family members are acknowledged as key contributors to the care of older people

7. Where possible unnecessary admissions to hospital or premature admissions to long-term residential aged care are avoided

8. Health and aged care professionals involved in caring for older people have the skills necessary to manage older people's specific needs

9. Available government resources are maximised across the acute-aged care continuum through intersectoral collaboration.

Principles guiding implementation of the National Action Plan are shown below and provided an opportunity to gather feedback from an aged care industry directly affected by the Plan. The principles are:

1. Older people have access to an appropriate level of health and aged care services that match their changing needs

2. Services are shaped around the diverse needs of older people

3. Avoidable admissions to hospitals or premature admissions to long-term residential aged care are prevented where possible

4. Older people have access to transition care services within the acute-aged care continuum

5. Service provider and government level operate to deliver an integrated suite of services and care for older people across the acute-aged care continuum

6. The workforce involved in caring for older people is skilled, responsive and in sufficient numbers to meet older people's needs

7. Informal carers and family members are well equipped to provide support and care

17.1.1 Selecting observable aspects of best practice

As consumers of public hospital services and as advocates for residents accessing hospital services, aged care personnel are in a strong position to observe processes and approaches taken by hospital staff during their work with residents transferring periodically into and from hospitals, as they would do if living in the general community.

Respondents to this survey were asked whether they agree that the statements of principle and standards made by these various national reports about whether the care and treatment of older people does occur. The responses reflect respondent perceptions of situations related to these principles and guidelines. It is therefore fair to assume that their perceptions have been built up over time based on personal experiences in dealing with the hospital system on behalf of residents moving between services.

The survey offered eight statements of best practice approaches in transfers from hospital to residential aged care for respondents to consider in terms of whether in their experience, these were being achieved by hospitals in their local area.

Question 28

Acute hospitals provide older people with healthcare that is person-centred and evidence-based in relation to transfers to residential aged care

Question 29

Acute hospitals provide older people with access before, during and following transfer to residential aged care, to appropriate levels of health and aged care services that match their changing needs

Question 30

Acute hospitals provide services before, during and following transfer to residential aged care, that are shaped around the diverse needs of older people

Question 31

Acute hospitals work to prevent avoidable admissions to hospital or premature admissions to long-term residential aged care where possible

Question 32

Older people have access to transition care services within the acute hospital – residential aged care continuum

Question 33

Acute hospitals work with aged care and government departments to deliver an integrated suite of services and care for older people across the acute hospital – residential aged care continuum

Question 34

Workforce involved in caring for older people are skilled, responsive and in sufficient numbers to meet older people's needs during transfers from hospital to residential aged care

Question 35

Informal carers and family members are well equipped to provide support and care for older people during transfers from hospital to residential aged care

17.2 Analysis of responses

Initially it was planned to analyse responses to the above questions using weighted scores to acknowledge the intensity of agreement or disagreement. However when both 'mildly' and 'strongly' worded responses were weighted, very little by way of positive responses emerged.

In order to extract some positive messages from the data intensity weightings were removed.

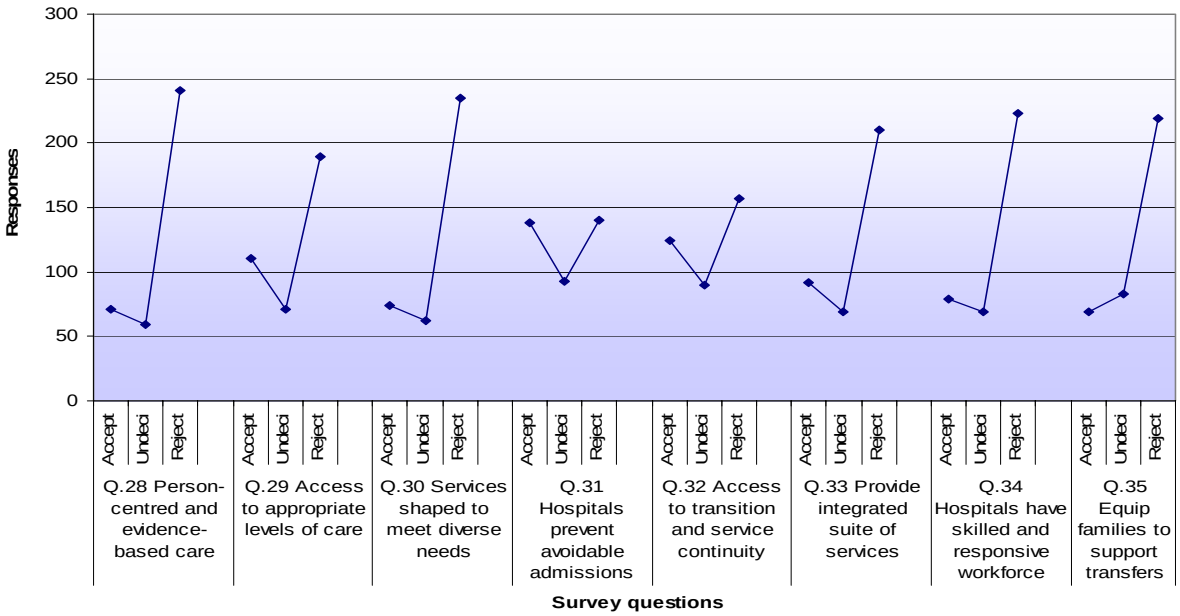
Results weighted for 'strongly' and 'mildly' responses:

Question	NSW	QLD	VIC/TAS	SA	WA	AUSTRALIA
28	-0.52	-0.92	-0.92	-0.49	-0.79	-0.74
29	-0.01	-0.72	-0.43	+0.04	-0.71	-0.36
30	-0.43	-0.94	-0.81	-0.62	-0.71	-0.70
31	+0.33	-0.10	-0.16	-0.22	-0.36	-0.05
32	-0.02	-0.44	-0.10	-0.22	-0.48	-0.22
33	-0.39	-0.71	-0.50	-0.36	-0.79	-0.53
34	-0.40	-0.80	-0.55	-0.76	-0.76	-0.62
35	-0.62	-0.72	-0.58	-0.62	-0.52	-0.62

This alternative approach allocates equal weights to 'mildly' and 'strongly' worded responses so that categories of 'accept the proposition', 'reject the proposition' or 'undecided' can allow some positive responses to surface.

Even so, from the chart shown below, the evidence is overwhelming that respondents from the aged care industry have a poor view of the quality of care, management and treatment of older people in hospitals, and also of efforts taken by hospital staff to ensure that residents are safely returned to their home.

Australia-wide perceptions of hospital achievement of best practice principles for care of older people in hospitals



State variations in responses also provide an overview of impressions held by respondents about acute hospital services in their State and in relation to achievement of these eight best practice principles.

In the following sections each statement or principle of best practice is shown in relation to the Australia-wide response and then for each State. The geographic location of respondents is also shown as this could have some bearing on their evaluation of hospital services in relation to treatment and transfers of residents.

Differences were apparent between States and these differences could indicate the relationship between aged care providers and the hospital system in that State. Even so, on the basis of their dealings with the hospital sector, most respondents could not support the statement in Question 28 as a true reflection of their experiences.

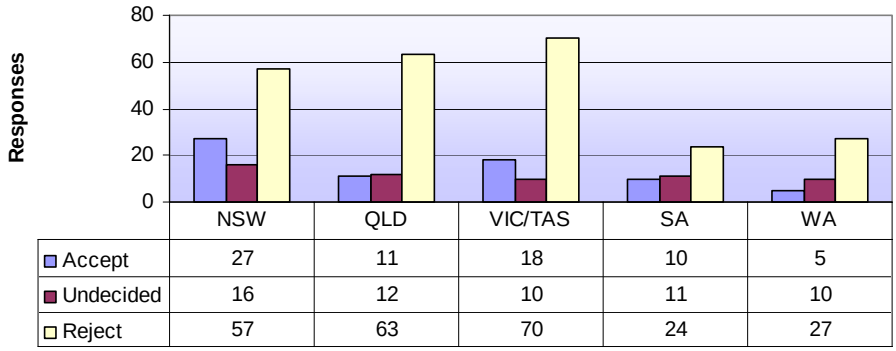
Question 28

"Acute hospitals provide older people with healthcare that is person-centred and evidence-based in relation to transfers to residential aged care"

Respondent views:	Responses	% Responses
Strongly disagree	124	33.42
Mildly disagree	117	31.54
Neither agree nor disagree	59	15.90
Mildly agree	53	14.29
Strongly agree	18	4.85
Total responses:	371	100.00

NSW has the best result with 27% agreeing with the statement followed by Victoria with 19% agreeing. Only 12% of Western Australian respondents agree with the statement on hospital performance in this area.

Acute hospitals provide older people with person-centred and evidence-based health care during transfers



	NSW	QLD	VIC/TAS	SA	WA
Accept	27	11	18	10	5
Undecided	16	12	10	11	10
Reject	57	63	70	24	27

It is possible that formal and informal arrangements set up between industry sectors could influence the working relationships between hospitals and aged care providers and particularly, provide opportunities for greater understanding between staff of constraints under which both services operate.

The information collected on organisational relationship arrangements has been applied to these evaluations of quality standards in order to discover whether agreements improve the safety and care or residents transferring between hospital and aged care services.

For each quality standard statement of best practice, responses were tabulated in terms of the type of agreement in place and whether different agreement arrangements affect the level of acceptance by aged care staff of best practice claims by hospitals.

Tables for each State showing respondents' location and their level of endorsement for each best practice statement are shown on the following pages. Across Australia respondents to the survey expressed their combined view on whether hospitals provide person-centred and evidence based care when transferring people to residential aged care and less than 20% of these combined respondents agreed with the statement. The table below adds a further dimension in terms of whether agreements between hospitals and aged care facilities influence these views of aged care staff.

Australia-wide agreements in place

"Acute hospitals provide older people with healthcare that is person-centred and evidence-based in relation to transfers to residential aged care"

			Agree	Disagree	Unsure	Total
Types of agreement in place between RACF and hospital	**None**	Count	16	98	26	140
		% response	11.4%	70.0%	18.6%	100.0%
		% of Total	4.3%	26.4%	7.0%	37.7%
	Formal	Count	7	13	2	22
		% response	31.8%	59.1%	9.1%	100.0%
		% of Total	1.9%	3.5%	.5%	5.9%
	Informal	Count	46	129	30	205
		% response	22.4%	62.9%	14.6%	100.0%
		% of Total	12.4%	34.8%	8.1%	55.3%
	Both	Count	2	1	1	4
		% response	50.0%	25.0%	25.0%	100.0%
		% of Total	.5%	.3%	.3%	1.1%
	Total	Count	71	241	59	371
		% response	19.1%	65.0%	15.9%	100.0%
		% of Total	19.1%	65.0%	15.9%	100.0%

Clearly more of the small group of respondents with both formal and informal agreements in place agree that hospitals achieve this target than those claiming to have other types of arrangements.

18.1 New South Wales

In NSW significantly more people in large metropolitan and suburban areas agree that hospitals are achieving best practice as described in this statement.

NSW *"Acute hospitals provide older people with healthcare that is person-centred and evidence-based related to transfers to residential aged care"*

Location of facility		Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	15	18	6	39
	% category	38.46	46.15	15.38	100.00
	% of Total	15.00	18.00	6.00	39.00
Large regional	Count	3	15	2	20
	% category	15.00	75.00	10.00	100.00

centre	% of Total	3.00	15.00	2.00	20.00
Small country town or village	Count	1	10	0	11
	% category	9.09	90.91	0.00	100.00
	% of Total	1.00	10.00	0.00	11.00
Outer suburbs of city	Count	8	14	8	30
	% category	26.67	46.67	26.67	100.00
	% of Total	8.00	14.00	8.00	30.00
Total	Count	27	57	16	100
	% category	27.00	57.00	16.00	100.00
	% of Total	27.00	57.00	16.00	100.00

18.2 Queensland

In Queensland very few respondents agree with the statement about hospital performance and they are quite unambiguous in their assessment with very small numbers unsure of their views.

QLD *"Acute hospitals provide older people with healthcare that is person-centred and evidence-based related to transfers to residential aged care"*

Location of facility		Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	3	15	1	19
	% category	15.79	78.95	5.26	100.00
	% of Total	3.49	17.44	1.16	22.09
Large regional centre	Count	5	19	3	27
	% category	18.52	70.37	11.11	100.00
	% of Total	5.81	22.09	3.49	31.40
Small country town or village	Count	3	12	4	19
	% category	15.79	63.16	21.05	100.00
	% of Total	3.49	13.95	4.65	22.09
Outer suburbs of city	Count	0	17	4	21
	% category	0.00	80.95	19.05	100.00
	% of Total	0.00	19.77	4.65	24.42
Total	Count	11	63	12	86
	% category	12.79	73.26	13.95	100.00
	% of Total	12.79	73.26	13.95	100.00

18.3 South Australia

South Australian respondents show a little more diversity of opinion with the proportion of country town views being more positive although many remain unsure. Negative views of the performance of large metropolitan centres are fairly unambivalent; whereas large regional centres had a large proportion of respondents who are unsure. No so for suburban areas where again their negative assessment is quite unequivocal.

SA *"Acute hospitals provide older people with healthcare that is person-centred and evidence-based related to transfers to residential aged care"*

Location of facility		Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	3	12	4	19
	% category	15.79	63.16	21.05	100.00
	% of Total	6.67	26.67	8.89	42.22
Large regional centre	Count	1	3	4	8
	% category	12.50	37.50	50.00	100.00
	% of Total	2.22	6.67	8.89	17.78
Small country town or village	Count	4	2	2	8
	% category	50.00	25.00	25.00	100.00
	% of Total	8.89	4.44	4.44	17.78
Outer suburbs of city	Count	2	7	1	10
	% category	20.00	70.00	10.00	100.00
	% of Total	4.44	15.56	2.22	22.22
Total	Count	10	24	11	45
	% category	22.22	53.33	24.44	100.00
	% of Total	22.22	53.33	24.44	100.00

18.4 Victoria and Tasmania

Victorian and Tasmanian respondents are quite damning of acute hospitals in large metropolitan and regional centres as well as country towns. They are less critical in the outer suburbs however overall responses are very negative in every location.

VIC/TAS *"Acute hospitals provide older people with healthcare that is person-centred and evidence-based related to transfers to residential aged care"*

Location of facility		Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	4	30	1	35
	% category	11.43	85.71	2.86	100.00
	% of Total	4.08	30.61	1.02	35.71
Large regional centre	Count	0	12	0	12
	% category	0.00	100.00	0.00	100.00
	% of Total	0.00	12.24	0.00	12.24
Small country town or village	Count	5	16	4	25
	% category	20.00	64.00	16.00	100.00
	% of Total	5.10	16.33	4.08	25.51
Outer suburbs of city	Count	9	12	5	26
	% category	34.62	46.15	19.23	100.00
	% of Total	9.18	12.24	5.10	26.53

	Count	18	70	10	98
	% category	18.37	71.43	10.20	100.00
Total	% of Total	18.37	71.43	10.20	100.00

18.5 Western Australia

Respondents from Western Australia are more unsure than in agreement with claims that hospitals are achieving this performance standard.

While most responses were received from metropolitan areas, the pattern of strong disagreement with the statement is reflected across all locations in this State.

WA *"Acute hospitals provide older people with healthcare that is person-centred and evidence-based related to transfers to residential aged care"*

Location of facility		Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	2	14	5	21
	% category	9.52	66.67	23.81	100.00
	% of Total	4.76	33.33	11.90	50.00
Large regional centre	Count	1	6	2	9
	% category	11.11	66.67	22.22	100.00
	% of Total	2.38	14.29	4.76	21.43
Small country town or village	Count	0	0	1	1
	% category	0.00	0.00	100.00	100.00
	% of Total	0.00	0.00	2.38	2.38
Outer suburbs of city	Count	2	7	2	11
	% category	18.18	63.64	18.18	100.00
	% of Total	4.76	16.67	4.76	26.19
Total	Count	5	27	10	42
	% category	11.90	64.29	23.81	100.00
	% of Total	11.90	64.29	23.81	100.00

19 Appropriate levels of health and aged care services

The question of whether or not hospitals provide older people with access to appropriate levels of care and services was put to 371 respondents across Australia. Aggregate responses are shown below with less than 10% able to say that they strongly agree with the claim that hospitals achieve this quality outcome.

Question 29

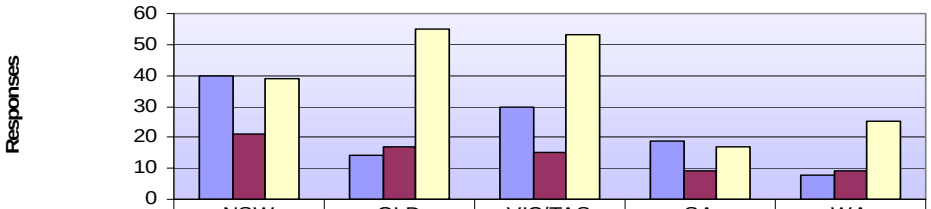
"Acute hospitals provide older people with access before, during and following transfer to residential aged care, to appropriate levels of health and aged care services that match their changing needs"

Respondent views:	Responses	% Responses
Strongly disagree	82	22.1
Mildly disagree	107	28.84
Neither agree nor disagree	71	19.14
Mildly agree	84	22.64
Strongly agree	27	7.28
Total Answers:	371	100.00

On combined tally, the chart below shows that NSW respondents think this statement about hospitals is more true than false. Even so, a large number of respondents (21%) could not decide and almost an equal number (39%) disagree with the statement. Similarly in South Australia 42% of respondents agree with the statement.

The division of opinion was clearer in Queensland and Victoria/Tasmania with the vast majority disagreeing with the statement. In Victoria however, almost 1:3 respondents agree that hospitals provide appropriate levels of health and aged care that changed to meet the needs of older people.

Appropriate levels of health and aged care services are provided by hospitals to older people transferring to aged care



	NSW	QLD	VIC/TAS	SA	WA
Accept	40	14	30	19	8
Undecided	21	17	15	9	9
Reject	39	55	53	17	25

In terms of whether agreements between hospitals and aged care have any effect on the perceptions of aged care staff about whether hospitals provide appropriate levels of health and aged care services, particularly in relation to resident transfers, is demonstrated in the table below.

Those with formal agreements are less unsure about their views on hospital performance but still more of them feel that hospitals do not achieve this quality

performance standard. Those with informal agreements seem slightly less polarized in their views however over half still believe that hospital performance on this target is not being achieved.

In the group with no agreements more think that hospitals achieve this target than those who are unsure, however the majority disagree with the idea that hospitals perform well in this area.

Australia-wide agreements in place

"Acute hospitals provide older people with access before, during and following transfer to residential aged care, to appropriate levels of health and aged care services that match their changing needs"

			Agree	Disagree	Unsure	Total
Types of agreements in place between RACF and hospital	**None**	Count	37	77	26	140
		% category	26.4%	55.0%	18.6%	100.0%
		% of Total	10.0%	20.8%	7.0%	37.7%
	Formal	Count	7	12	3	22
		% category	31.8%	54.5%	13.6%	100.0%
		% of Total	1.9%	3.2%	.8%	5.9%
	Informal	Count	65	100	40	205
		% category	31.7%	48.8%	19.5%	100.0%
		% of Total	17.5%	27.0%	10.8%	55.3%
	Both	Count	2	0	2	4
		% category	50.0%	.0%	50.0%	100.0%
		% of Total	.5%	.0%	.5%	1.1%
	Total	Count	Count	189	71	371
		% category	30.0%	50.9%	19.1%	100.0%
		% of Total	30.0%	50.9%	19.1%	100.0%

Whether or not different locations within each State have an effect on responses is considered in the tables that follow. Despite overall indications of disagreement with hospital claims of achieving these quality outcomes it is important to identify locations with more positive feedback.

19.1 New South Wales

NSW hospitals in metropolitan and suburban areas seem to be more highly regarded by aged care staff than those in regional and country areas.

In outer suburban areas there is almost double the proportion of respondents agreeing with the statement than disagreeing with it. Still, a large proportion of people in this location are unsure about whether hospitals do provide older people with access to appropriate levels of health and aged care.

NSW *"Acute hospitals provide older people with access before, during and following transfer to residential aged care, to appropriate levels of health and aged care services that match their changing needs"*

Location of facility		Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	18	14	7	39
	% category	46.15	35.90	17.95	100.00
	% of Total	18.00	14.00	7.00	39.00
Large regional centre	Count	6	11	3	20
	% category	30.00	55.00	15.00	100.00
	% of Total	6.00	11.00	3.00	20.00
Small country town or village	Count	2	7	2	11
	% category	18.18	63.64	18.18	100.00
	% of Total	2.00	7.00	2.00	11.00
Outer suburbs of city	Count	14	7	9	30
	% category	46.67	23.33	30.00	100.00
	% of Total	14.00	7.00	9.00	30.00
Total	Count	40	39	21	100
	% category	40.00	39.00	21.00	100.00
	% of Total	40.00	39.00	21.00	100.00

19.2 Queensland

Queensland respondents from small country towns compared with other locations hold the most positive views of hospital performance against this quality target with the lowest level of uncertainty. 57.89% disagree with the claim that hospitals provide appropriate levels of care as stated. In all other locations the proportion of respondents disagreeing with the claim is unequivocal.

QLD *"Acute hospitals provide older people with access before, during and following transfer to residential aged care, to appropriate levels of health and aged care services that match their changing needs"*

Location of facility		Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	3	14	2	19
	% category	15.79	73.68	10.53	100.00
	% of Total	3.49	16.28	2.33	22.09
Large regional centre	Count	3	18	6	27
	% category	11.11	66.67	22.22	100.00
	% of Total	3.49	20.93	6.98	31.40
Small country town or village	Count	5	11	3	19
	% category	26.32	57.89	15.79	100.00
	% of Total	5.81	12.79	3.49	22.09
Outer suburbs of city	Count	3	12	6	21
	% category	14.29	57.14	28.57	100.00
	% of Total	3.49	13.95	6.98	24.42

	Count	14	55	17	86
	% category	16.28	63.95	19.77	100.00
Total	% of Total	16.28	63.95	19.77	100.00

19.3 South Australia

In South Australia respondents from large metropolitan areas are more unsure about hospital performance against this standard than they are in agreement. In every other location more respondents agree that hospitals are achieving this quality outcome than those who clearly disagree with the claim.

SA *"Acute hospitals provide older people with access before, during and following transfer to residential aged care, to appropriate levels of health and aged care services that match their changing needs"*

	Location of facility	Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	5	8	6	19
	% category	26.32	42.11	31.58	100.00
	% of Total	11.11	17.78	13.33	42.22
Large regional centre	Count	4	3	1	8
	% category	50.00	37.50	12.50	100.00
	% of Total	8.89	6.67	2.22	17.78
Small country town or village	Count	5	2	1	8
	% category	62.50	25.00	12.50	100.00
	% of Total	11.11	4.44	2.22	17.78
Outer suburbs of city	Count	5	4	1	10
	% category	50.00	40.00	10.00	100.00
	% of Total	11.11	8.89	2.22	22.22
Total	Count	19	17	9	45
	% category	42.22	37.78	20.00	100.00
	% of Total	42.22	37.78	20.00	100.00

19.4 Victoria and Tasmania

The Victorian and Tasmanian combined views on this statement are interesting. Almost the same proportion of people in outer suburban areas both agree and disagree that hospitals are achieving the target, and a large group from this location remains unsure. No such ambivalence in the large regional centres where 83.33% disagree with the claim,

VIC/TAS *"Acute hospitals provide older people with access before, during and following transfer to residential aged care, to appropriate levels of health and aged care services that match their changing needs"*

	Location of facility	**Agree**	**Disagree**	**Unsure**	**Total**
Large metropolitan centre	Count	12	19	4	35
	% category	34.29	54.29	11.43	100.00
	% of Total	12.24	19.39	4.08	35.71

Large regional centre	Count	1	10	1	12
	% category	8.33	83.33	8.33	100.00
	% of Total	1.02	10.20	1.02	12.24
Small country town or village	Count	7	13	5	25
	% category	28.00	52.00	20.00	100.00
	% of Total	7.14	13.27	5.10	25.51
Outer suburbs of city	Count	10	11	5	26
	% category	38.46	42.31	19.23	100.00
	% of Total	10.20	11.22	5.10	26.53
Total	Count	30	53	15	98
	% category	30.61	54.08	15.31	100.00
	% of Total	30.61	54.08	15.31	100.00

19.5 Western Australia

Western Australian respondents from the outer suburbs are most strongly in agreement that hospital performance meets the standard as claimed. Even so, over half disagree that hospitals provide appropriate levels of health and aged care and adapt services to changing needs of older people. Large metropolitan centre responses show more respondents unsure than those in agreement, and both groups are overshadowed by the 57.14% who completely disagree with any suggestion that hospitals are achieving this quality target.

WA *"Acute hospitals provide older people with access before, during and following transfer to residential aged care, to appropriate levels of health and aged care services that match their changing needs"*

	Location of facility	Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	4	12	5	21
	% category	19.05	57.14	23.81	100.00
	% of Total	9.52	28.57	11.90	50.00
Large regional centre	Count	1	6	2	9
	% category	11.11	66.67	22.22	100.00
	% of Total	2.38	14.29	4.76	21.43
Small country town or village	Count	0	1	0	1
	% category	0.00	100.00	0.00	100.00
	% of Total	0.00	2.38	0.00	2.38
Outer suburbs of city	Count	3	6	2	11
	% category	27.27	54.55	18.18	100.00
	% of Total	7.14	14.29	4.76	26.19
Total	Count	8	25	9	42
	% category	19.05	59.52	21.43	100.00
	% of Total	19.05	59.52	21.43	100.00

20 Hospital services shaped around older people's needs

Even fewer respondents (less than 5%) than for the previous question are able to strongly agree with this claim that hospitals shape their services around the various needs of older people in relation to transfer to residential aged care.

Question 30

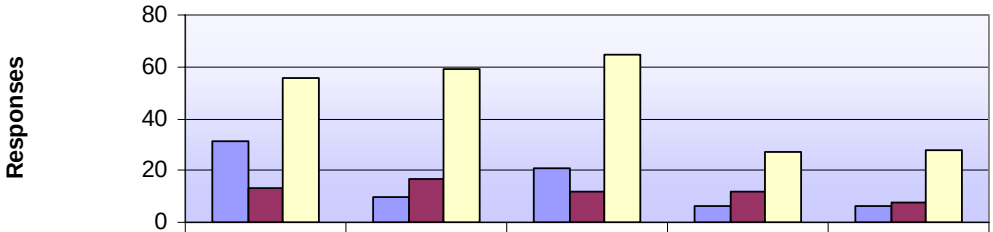
"Acute hospitals provide services before, during and following transfer to residential aged care, that are shaped around the diverse needs of older people"

Respondent views:	Responses	% Responses
Strongly disagree	116	31.27
Mildly disagree	119	32.08
Neither agree nor disagree	62	16.71
Mildly agree	58	15.63
Strongly agree	16	4.31
Total Answers:	371	100.00

Similar to the previous question, this statement acknowledges the best practice principle of services being sufficiently flexible to meet the diverse needs of older people who may be admitted for one health issue but also be dealing with several other health problems. The table above shows the intensity of responses with almost one third of respondents strongly disagreeing that this best practice occurs in the hospitals they encounter.

At a State level the rejection of this statement as being true is strongly apparent in every area however in NSW some respondents (31%) felt they could agree even if only mildly.

Needs-based hospital services are provided to older people during transfer to aged care



	NSW	QLD	VIC/TAS	SA	WA
Accept	31	10	21	6	6
Undecided	13	17	12	12	8
Reject	56	59	65	27	28

The combined views Australia-wide are shown below in relation to whether some form of agreement is in place between aged care and hospitals. It seems that the presence of such an agreement can affect the perception of aged care staff as to whether hospitals achieve this quality outcome.

The table below shows that respondents with formal agreements in place agree more with the statement and have less uncertainty and less disagreement with

hospital claims of reaching the performance target contained in the statement, than do respondents in every other category of agreement or lack of same. Those with informal agreements also fare better than those with none, however high levels of uncertainty remain along with a clearly dominant view that hospital performance is not as claimed in relation to shaping their services to meet the needs of older people in residential aged care transfer situations.

Australia-wide agreements in place

"Acute hospitals provide services before, during and following transfer to residential aged care, that are shaped around the diverse needs of older people"

			Agree	Disagree	Unsure	Total
Types of agreement in place between RACF and hospital	**None**	Count	20	96	24	140
		% category	14.3%	68.6%	17.1%	100.0%
		% of Total	5.4%	25.9%	6.5%	37.7%
	Formal	Count	6	13	3	22
		% category	27.3%	59.1%	13.6%	100.0%
		% of Total	1.6%	3.5%	.8%	5.9%
	Informal	Count	46	125	34	205
		% category	22.4%	61.0%	16.6%	100.0%
		% of Total	12.4%	33.7%	9.2%	55.3%
	Both	Count	2	1	1	4
		% category	50.0%	25.0%	25.0%	100.0%
		% of Total	.5%	.3%	.3%	1.1%
	Total	Count	74	235	62	371
		% category	19.9%	63.3%	16.7%	100.0%
		% of Total	19.9%	63.3%	16.7%	100.0%

20.1 New South Wales

Respondents in NSW suburban areas agree more often than disagree with the statement that hospitals provide services to older people that are shaped around their needs related to transfer to aged care.

Metropolitan area respondents certainly disagree with the proposition although one in three respondents do agree with it. Country towns and regional area respondents are very sure that they disagree with the statement that hospitals achieve this quality outcome.

NSW *"Acute hospitals provide services before, during and following transfer to residential aged care, shaped around the diverse needs of older people"*

	Location of facility	Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	13	18	8	39
	% category	33.33	46.15	20.51	100.00
	% of Total	13.00	18.00	8.00	39.00

Large regional centre	Count	3	16	1	20
	% category	15.00	80.00	5.00	100.00
	% of Total	3.00	16.00	1.00	20.00
Small country town or village	Count	1	10	0	11
	% category	9.09	90.91	0.00	100.00
	% of Total	1.00	10.00	0.00	11.00
Outer suburbs of city	Count	14	12	4	30
	% category	46.67	40.00	13.33	100.00
	% of Total	14.00	12.00	4.00	30.00
Total	Count	31	56	13	100
	% category	31.00	56.00	13.00	100.00
	% of Total	31.00	56.00	13.00	100.00

20.2 Queensland

While very few respondents from Queensland ware able to agree that hospitals achieve this quality outcome in relation to transfers, quite a few are unsure about their views. The largest groups of uncertain people are from country towns and large metropolitan areas.

Overall though, the verdict of Queensland respondents is that they disagree with any claim that hospitals are performing adequately on this standard.

QLD | *"Acute hospitals provide services before, during and following transfer to residential aged care, shaped around the diverse needs of older people"*

Location of facility		Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	1	13	5	19
	% category	5.26	68.42	26.32	100.00
	% of Total	1.16	15.12	5.81	22.09
Large regional centre	Count	5	19	3	27
	% category	18.52	70.37	11.11	100.00
	% of Total	5.81	22.09	3.49	31.40
Small country town or village	Count	3	10	6	19
	% category	15.79	52.63	31.58	100.00
	% of Total	3.49	11.63	6.98	22.09
Outer suburbs of city	Count	1	17	3	21
	% category	4.76	80.95	14.29	100.00
	% of Total	1.16	19.77	3.49	24.42
Total	Count	10	59	17	86
	% category	11.63	68.60	19.77	100.00
	% of Total	11.63	68.60	19.77	100.00

20.3 South Australia

In South Australia all respondents except those from country towns clearly believe that hospitals in cities, suburbs and large regional areas are failing to achieve the level of care of older people that the statement suggests.

In small towns 37.5% of respondents disagree with the statement but an equal proportion are unsure.

SA | *"Acute hospitals provide services before, during and following transfer to residential aged care, shaped around the diverse needs of older people"*

Location of facility		Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	2	10	7	19
	% category	10.53	52.63	36.84	100.00
	% of Total	4.44	22.22	15.56	42.22
Large regional centre	Count	0	6	2	8
	% category	0.00	75.00	25.00	100.00
	% of Total	0.00	13.33	4.44	17.78
Small country town or village	Count	2	3	3	8
	% category	25.00	37.50	37.50	100.00
	% of Total	4.44	6.67	6.67	17.78
Outer suburbs of city	Count	2	8	0	10
	% category	20.00	80.00	0.00	100.00
	% of Total	4.44	17.78	0.00	22.22
Total	Count	6	27	12	45
	% category	13.33	60.00	26.67	100.00
	% of Total	13.33	60.00	26.67	100.00

20.4 Victoria and Tasmania

Combined respondents from small towns in Victoria and Tasmania are more likely to agree or not have a view, than are prepared to say they disagree with the claim that hospitals are providing this standard of services to older people. In some small way this is a positive for country areas because in all other locations their views unambiguously disagree.

VIC/ TAS | *"Acute hospitals provide services before, during and following transfer to residential aged care, shaped around the diverse needs of older people"*

Location of facility		Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	7	25	3	35
	% category	20.00	71.43	8.57	100.00
	% of Total	7.14	25.51	3.06	35.71
Large regional centre	Count	0	12	0	12
	% category	0.00	100.00	0.00	100.00
	% of Total	0.00	12.24	0.00	12.24

Small country town or village	Count	7	12	6	25
	% category	28.00	48.00	24.00	100.00
	% of Total	7.14	12.24	6.12	25.51
Outer suburbs of city	Count	7	16	3	26
	% category	26.92	61.54	11.54	100.00
	% of Total	7.14	16.33	3.06	26.53
Total	Count	21	65	12	98
	% category	21.43	66.33	12.24	100.00
	% of Total	21.43	66.33	12.24	100.00

20.5 Western Australia

Western Australian respondents are also in broad disagreement with the claim that hospitals provide this level of quality service however the proportion of respondents who are unsure of their views is similar to those who agree with the claim that hospitals provide services shaped around the diverse needs of older people being transferred to aged care.

WA | *"Acute hospitals provide services before, during and following transfer to residential aged care, shaped around the diverse needs of older people"*

Location of facility		Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	3	15	3	21
	% category	14.29	71.43	14.29	100.00
	% of Total	7.14	35.71	7.14	50.00
Large regional centre	Count	1	6	2	9
	% category	11.11	66.67	22.22	100.00
	% of Total	2.38	14.29	4.76	21.43
Small country town or village	Count	0	1	0	1
	% category	0.00	100.00	0.00	100.00
	% of Total	0.00	2.38	0.00	2.38
Outer suburbs of city	Count	2	6	3	11
	% category	18.18	54.55	27.27	100.00
	% of Total	4.76	14.29	7.14	26.19
Total	Count	6	28	8	42
	% category	14.29	66.67	19.05	100.00
	% of Total	14.29	66.67	19.05	100.00

21 Preventing avoidable admissions

The pathway to aged care placement often follows a health crisis that is dealt with initially by acute hospitals and then a referral is made following an Aged Care Assessment Team (ACAT) determination of eligibility. Avoidable admissions to hospital refer to a policy of trying to effectively treat and manage older people away from acute hospitals wherever possible. There is widespread support for these approaches being implemented and are supported by the aged care industry, provided they are not enacted in ways that disadvantage older people in terms of equal access to hospital services, or preventing them and their families from accessing aged care services that they need.

Question 31

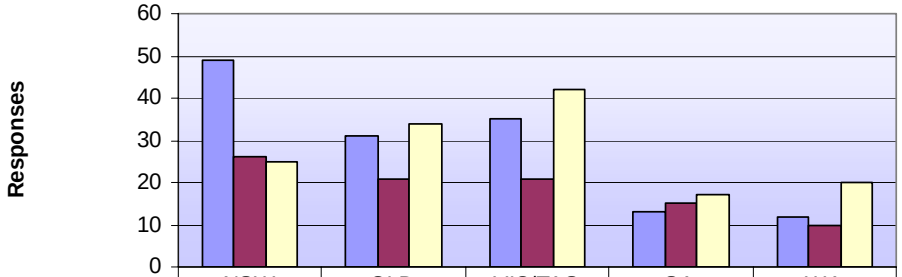
"Acute hospitals work to prevent avoidable admissions to hospital or premature admissions to long-term residential aged care where possible"

Respondent views:	Responses	% Responses
Strongly disagree	59	15.9
Mildly disagree	79	21.29
Neither agree nor disagree	93	25.08
Mildly agree	100	26.95
Strongly agree	40	10.78
Total Answers:	371	100.00

Responses to this question shown above indicate strong disagreement at a minimum (15.9%) as is strong agreement (10.78%). Overall most respondents are in mild agreement with the statement while 1:4 respondents are undecided.

At the State level it is clear from the graph below that in NSW respondents agree, albeit mildly, with the statement of best practice in relation to preventing avoidable admissions to hospital and premature admissions to long term residential care. In every other State respondents reject the proposition more often than accept it.

Avoidable admissions to hospital and premature admissions to long-term residential care are prevented



	NSW	QLD	VIC/TAS	SA	WA
Accept	49	31	35	13	12
Undecided	26	21	21	15	10
Reject	25	34	42	17	20

From across Australia aggregate responses to the proposition that acute hospitals work to prevent avoidable admissions and premature aged care placement, are shown in the table below. Again these responses have been cross-tabulated with any type of agreements that might exist between aged care and hospital services in relation to resident care and safety.

Aged care providers with formal agreements are more likely to agree that hospitals are meeting standards they set for themselves on this issue, than those with no agreement or an informal arrangement. Formal agreements seem to reduce uncertainty about whether hospital standards are met in this regard. Something not able to be said for those relying on informal or no agreements.

Australia-wide agreements in place

"Acute hospitals work to prevent avoidable admissions to hospital or premature admissions to long-term residential aged care where possible"

			Agree	Disagree	Unsure	Total
Types of agreement in place between RACF and hospital	**None**	Count	46	57	37	140
		% category	32.9%	40.7%	26.4%	100.0%
		% of Total	12.4%	15.4%	10.0%	37.7%
	Formal	Count	13	6	3	22
		% category	59.1%	27.3%	13.6%	100.0%
		% of Total	3.5%	1.6%	.8%	5.9%
	Informal	Count	77	75	53	205
		% category	37.6%	36.6%	25.9%	100.0%
		% of Total	20.8%	20.2%	14.3%	55.3%
	Both	Count	4	0	0	4
		% category	100.0%	.0%	.0%	100.0%
		% of Total	1.1%	.0%	.0%	1.1%
	Total	Count	140	138	93	371
		% category	37.7%	37.2%	25.1%	100.0%
		% of Total	37.7%	37.2%	25.1%	100.0%

21.1 New South Wales

NSW respondents from cities, suburbs and large regional centres agree with the proposition contained in this standard more than those who disagree with it. A significant number of respondents claim to be unsure of their views about hospital performance on this issue.

NSW *"Acute hospitals work to prevent avoidable admissions to hospital or premature admissions to long-term residential aged care where possible"*

	Location of facility	Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	21	10	8	39
	% category	53.85	25.64	20.51	100.00
	% of Total	21.00	10.00	8.00	39.00

Large regional centre	Count	7	6	7	20
	% category	35.00	30.00	35.00	100.00
	% of Total	7.00	6.00	7.00	20.00
Small country town or village	Count	3	6	2	11
	% category	27.27	54.55	18.18	100.00
	% of Total	3.00	6.00	2.00	11.00
Outer suburbs of city	Count	18	3	9	30
	% category	60.00	10.00	30.00	100.00
	% of Total	18.00	3.00	9.00	30.00
Total	Count	49	25	26	100
	% category	49.00	25.00	26.00	100.00
	% of Total	49.00	25.00	26.00	100.00

21.2 Queensland

In Queensland only respondents from large regional centres agree more than they disagree with the statement on hospitals preventing avoidable admissions. In every other location the majority disagree and this is especially so in the outer suburbs areas.

Quite a few respondents in every location are not able to decide if they agree or not … an interesting result considering the profile of respondents who participated in the survey.

QLD *"Acute hospitals work to prevent avoidable admissions to hospital or premature admissions to long-term residential aged care where possible"*

	Location of facility	Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	6	7	6	19
	% category	31.58	36.84	31.58	100.00
	% of Total	6.98	8.14	6.98	22.09
Large regional centre	Count	12	8	7	27
	% category	44.44	29.63	25.93	100.00
	% of Total	13.95	9.30	8.14	31.40
Small country town or village	Count	7	8	4	19
	% category	36.84	42.11	21.05	100.00
	% of Total	8.14	9.30	4.65	22.09
Outer suburbs of city	Count	6	11	4	21
	% category	28.57	52.38	19.05	100.00
	% of Total	6.98	12.79	4.65	24.42
Total	Count	31	34	21	86
	% category	36.05	39.53	24.42	100.00
	% of Total	36.05	39.53	24.42	100.00

21.3 South Australia

Respondents in South Australia from large metropolitan centres agree more than disagree with the statement made about hospitals working to prevent avoidable admissions. Even so, the largest proportion of respondents in this location remains undecided indicating a lack of confidence that hospitals are performing well on this standard. Overall respondents across most locations disagree with the suggestion that hospitals are achieving this outcome, but in country towns there seems to be a relatively even distribution between agreeing, disagreeing and not being sure.

SA *"Acute hospitals work to prevent avoidable admissions to hospital or premature admissions to long-term residential aged care where possible"*

Location of facility		Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	7	4	8	19
	% category	36.84	21.05	42.11	100.00
	% of Total	15.56	8.89	17.78	42.22
Large regional centre	Count	2	5	1	8
	% category	25.00	62.50	12.50	100.00
	% of Total	4.44	11.11	2.22	17.78
Small country town or village	Count	2	3	3	8
	% category	25.00	37.50	37.50	100.00
	% of Total	4.44	6.67	6.67	17.78
Outer suburbs of city	Count	2	5	3	10
	% category	20.00	50.00	30.00	100.00
	% of Total	4.44	11.11	6.67	22.22
Total	Count	13	17	15	45
	% category	28.89	37.78	33.33	100.00
	% of Total	28.89	37.78	33.33	100.00

21.4 Victoria and Tasmania

Respondents from the Victoria and Tasmania group mostly disagree with the statement except for those in the outer suburbs. The difference between the proportion agreeing and disagreeing is not great, but it is there along with 26.92% who are unsure. The spread of responses in relation to country towns is fairly even and therefore inconclusive.

VIC/ TAS *"Acute hospitals work to prevent avoidable admissions to hospital or premature admissions to long-term residential aged care where possible"*

Location of facility		Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	13	17	5	
	% category	37.14	48.57	14.29	
	% of Total	13.27	17.35	5.10	
Large regional centre	Count	3	7	2	
	% category	25.00	58.33	16.67	
	% of Total	3.06	7.14	2.04	

Small country town or village	Count	9	9	7
	% category	36.00	36.00	28.00
	% of Total	9.18	9.18	7.14
Outer suburbs of city	Count	10	9	7
	% category	38.46	34.62	26.92
	% of Total	10.20	9.18	7.14
Total	Count	35	42	21
	% category	35.71	42.86	21.43
	% of Total	35.71	42.86	21.43

21.5 Western Australia

In Western Australia the large metropolitan centres are the main focus of responses where over half of the respondents disagree with the proposition that hospitals are working to achieve this outcome. One third is unsure and a small group think it is occurring. A similar although not so dramatic result was received in relation to outer suburban areas.

WA *"Acute hospitals work to prevent avoidable admissions to hospital or premature admissions to long-term residential aged care where possible"*

Location of facility		Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	3	11	7	21
	% category	14.29	52.38	33.33	100.00
	% of Total	7.14	26.19	16.67	50.00
Large regional centre	Count	4	4	1	9
	% category	44.44	44.44	11.11	100.00
	% of Total	9.52	9.52	2.38	21.43
Small country town or village	Count	1	0	0	1
	% category	100.00	0.00	0.00	100.00
	% of Total	2.38	0.00	0.00	2.38
Outer suburbs of city	Count	4	5	2	11
	% category	36.36	45.45	18.18	100.00
	% of Total	9.52	11.90	4.76	26.19
Total	Count	12	20	10	42
	% category	28.57	47.62	23.81	100.00
	% of Total	28.57	47.62	23.81	100.00

On this principle of best practice, there is relatively widespread agreement with the statement that hospitals provide older people with access to transition services along the aged care – hospital continuum of care however very few agree strongly with the idea. A large group strongly disagreed with the suggestion that hospitals provide access to services that support a continuum between hospital and aged care services.

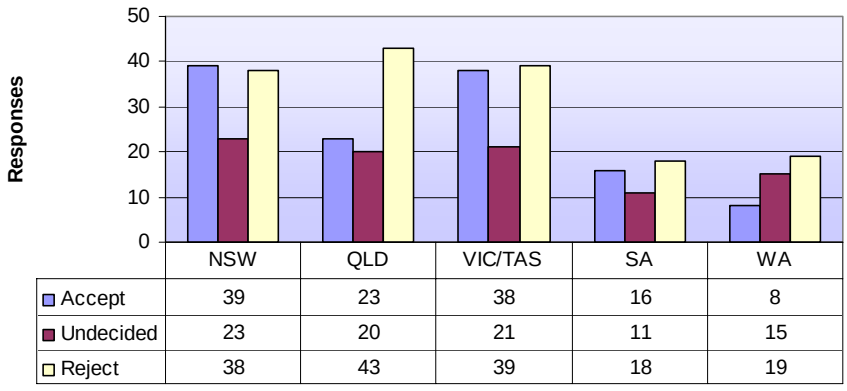
Question 32

"Older people have access to transition care services within the acute hospital–residential aged care continuum"

Respondent views:	Responses	% Responses
Strongly disagree	70	18.87
Mildly disagree	87	23.45
Neither agree nor disagree	90	24.26
Mildly agree	101	27.22
Strongly agree	23	6.2
Total Answers:	371	100.00

The State-wide picture below shows NSW and Victoria/Tasmania as being fairly evenly divided on the issue whereas Queensland shows a strong rejection of this statement. Western Australia has very few who agree, most of the respondents from that State either reject the notion or are undecided.

Older people have access to transition care services within the hospital-aged care continuum



	NSW	QLD	VIC/TAS	SA	WA
Accept	39	23	38	16	8
Undecided	23	20	21	11	15
Reject	38	43	39	18	19

When these responses are compared with the presence or absence of some type of service agreement between aged care and hospital services, it is interesting to note the effects on perceptions held about the standards of hospital services. In the table below those with formal agreements in place (or both) are far more likely to agree with the statement that hospitals provide access to transition care services, than those who have either informal agreements or none.

Again, the presence of a formal agreement also markedly reduces the level of uncertainty felt by respondents about this issue.

Australia-wide agreements in place

"Older people have access to transition care services within the acute hospital – residential aged care continuum"

			Agree	Disagree	Unsure	Total
Types of agreement between RACF and hospitals	**None**	Count	46	52	42	140
		% category	32.9%	37.1%	30.0%	100.0%
		% of Total	12.4%	14.0%	11.3%	37.7%
	Formal	Count	12	8	2	22
		% category	54.5%	36.4%	9.1%	100.0%
		% of Total	3.2%	2.2%	.5%	5.9%
	Informal	Count	63	96	46	205
		% category	30.7%	46.8%	22.4%	100.0%
		% of Total	17.0%	25.9%	12.4%	55.3%
	Both	Count	3	1	0	4
		% category	75.0%	25.0%	.0%	100.0%
		% of Total	.8%	.3%	.0%	1.1%
	Total	Count	124	157	90	371
		% category	33.4%	42.3%	24.3%	100.0%
		% of Total	33.4%	42.3%	24.3%	100.0%

22.1 New South Wales

NSW respondents from large regional centres and the outer suburbs are more often in agreement with this statement about hospitals than those who disagree. While a significant proportion of responses disagree, the level of uncertainty is relatively low.

Most disagreement seems to be happening in small towns with over half of the respondents declaring such views.

In large metropolitan areas the spread seems relatively even across the three response categories with a surprising level of uncertainty about what should be easily apparent, considering the profile of survey respondents.

NSW *"Older people have access to transition care services within the acute hospital – residential aged care continuum"*

Location of facility		Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	12	15	12	39
	% category	30.77	38.46	30.77	100.00
	% of Total	12.00	15.00	12.00	39.00
Large regional centre	Count	10	6	4	20
	% category	50.00	30.00	20.00	100.00
	% of Total	10.00	6.00	4.00	20.00

Small country town or village	Count	3	6	2	11
	% category	27.27	54.55	18.18	100.00
	% of Total	3.00	6.00	2.00	11.00
Outer suburbs of city	Count	14	11	5	30
	% category	46.67	36.67	16.67	100.00
	% of Total	14.00	11.00	5.00	30.00
Total	Count	39	38	23	100
	% category	39.00	38.00	23.00	100.00
	% of Total	39.00	38.00	23.00	100.00

22.2 Queensland

Across all Queensland locations most respondents disagree with the proposition that hospitals provide access to transition care across the hospital-aged care continuum.

People in metropolitan and suburban areas are most adamant in their disagreement while more are unsure than those who agree with the statement. Country and regional centres are less polarised on this issue however the majority disagree with the idea that hospitals are achieving this outcome.

QLD *"Older people have access to transition care services within the acute hospital – residential aged care continuum"*

Location of facility		Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	4	10	5	19
	% category	21.05	52.63	26.32	100.00
	% of Total	4.65	11.63	5.81	22.09
Large regional centre	Count	10	11	6	27
	% category	37.04	40.74	22.22	100.00
	% of Total	11.63	12.79	6.98	31.40
Small country town or village	Count	7	8	4	19
	% category	36.84	42.11	21.05	100.00
	% of Total	8.14	9.30	4.65	22.09
Outer suburbs of city	Count	2	14	5	21
	% category	9.52	66.67	23.81	100.00
	% of Total	2.33	16.28	5.81	24.42
Total	Count	23	43	20	86
	% category	26.74	50.00	23.26	100.00
	% of Total	26.74	50.00	23.26	100.00

22.3 South Australia

Respondents in South Australia who are from large metropolitan areas are slightly more likely to agree that hospitals achieve this quality outcome, however they seem evenly divided between agreeing, disagreeing and being unsure of their views.

Strong evidence of disagreement was received from respondents in suburban areas and in large regional centres.

SA *"Older people have access to transition care services within the acute hospital – residential aged care continuum"*

Location of facility		Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	7	6	6	19
	% category	36.84	31.58	31.58	100.00
	% of Total	15.56	13.33	13.33	42.22
Large regional centre	Count	3	4	1	8
	% category	37.50	50.00	12.50	100.00
	% of Total	6.67	8.89	2.22	17.78
Small country town or village	Count	2	2	4	8
	% category	25.00	25.00	50.00	100.00
	% of Total	4.44	4.44	8.89	17.78
Outer suburbs of city	Count	4	6	0	10
	% category	40.00	60.00	0.00	100.00
	% of Total	8.89	13.33	0.00	22.22
Total	Count	16	18	11	45
	% category	35.56	40.00	24.44	100.00
	% of Total	35.56	40.00	24.44	100.00

22.4 Victoria and Tasmania

The Victoria and Tasmania responses from large metropolitan areas indicate that more than half agree that hospitals there are providing access to older people in terms of transition care services. The outer suburbs are less clear in their views with responses fairly evenly spread across response categories. The strongest disagreement is seen in large regional centres with 66.67% in disagreement despite an equal level of agreement and uncertainty in that location.

VIC/TAS *"Older people have access to transition care services within the acute hospital – residential aged care continuum"*

Location of facility		Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	19	11	5	35
	% category	54.29	31.43	14.29	100.00
	% of Total	19.39	11.22	5.10	35.71
Large regional centre	Count	2	8	2	12
	% category	16.67	66.67	16.67	100.00
	% of Total	2.04	8.16	2.04	12.24
Small country town or village	Count	8	11	6	25
	% category	32.00	44.00	24.00	100.00
	% of Total	8.16	11.22	6.12	25.51

Outer suburbs of city	Count	9	9	8	26
	% category	34.62	34.62	30.77	100.00
	% of Total	9.18	9.18	8.16	26.53
Total	Count	38	39	21	98
	% category	38.78	39.80	21.43	100.00
	% of Total	38.78	39.80	21.43	100.00

22.5 Western Australia

Western Australian respondents in large regional centres are quite clear about their disagreement with the suggestion that hospitals are performing well against this standard. 77.78% disagree. The picture is less definite in city areas with the large metropolitan centre responses showing more people who are unsure than those who either agree or disagree.

WA *"Older people have access to transition care services within the acute hospital – residential aged care continuum"*

Location of facility		Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	4	8	9	21
	% category	19.05	38.10	42.86	100.00
	% of Total	9.52	19.05	21.43	50.00
Large regional centre	Count	1	7	1	9
	% category	11.11	77.78	11.11	100.00
	% of Total	2.38	16.67	2.38	21.43
Small country town or village	Count	0	0	1	1
	% category	0.00	0.00	100.00	100.00
	% of Total	0.00	0.00	2.38	2.38
Outer suburbs of city	Count	3	4	4	11
	% category	27.27	36.36	36.36	100.00
	% of Total	7.14	9.52	9.52	26.19
Total	Count	8	19	15	42
	% category	19.05	45.24	35.71	100.00
	% of Total	19.05	45.24	35.71	100.00

23 Integrated services across the care continuum

Cross-sectoral collaboration has been a catch-cry for health and aged care staff wanting to set up and maintain a comprehensive range of services and care for older people. Those who take a patient or client-centred approach to health and care services place older people as the central focus in planning and operationalising services.

The statement of best practice in this question refers to the idea of a continuum of care across different agencies and services. It implies that efforts are made by all involved to ensure that services are integrated and appropriate.

Question 33

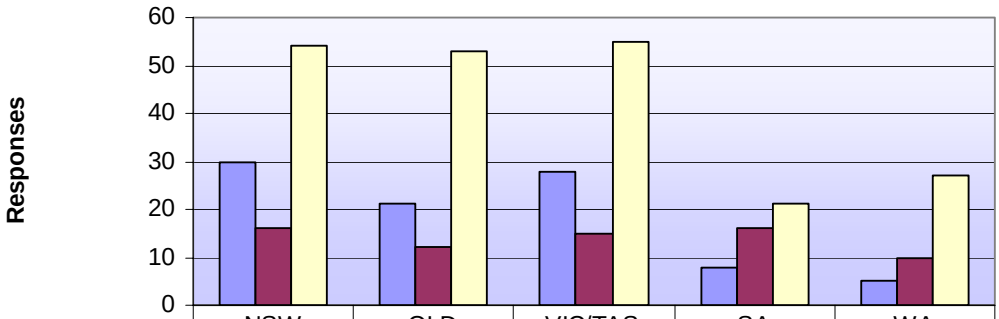
"Acute hospitals work with aged care and government departments to deliver an integrated suite of services and care for older people across the acute hospital – residential aged care continuum"

Respondent views:	Responses	% Responses
Strongly disagree	101	27.22
Mildly disagree	109	29.38
Neither agree nor disagree	69	18.6
Mildly agree	71	19.14
Strongly agree	21	5.66
Total Answers:	371	100.00

The response from the aged care industry shown above, demonstrates strong disagreement 56.6% (n=210) with the claim that high standards of care and services to older people occur in acute hospitals.

The distribution of responses across different States shown below indicates that respondents across all areas find it difficult to support the claim made in the statement.

Hospitals work with aged care and government agencies to deliver an integrated suite of services to older people



	NSW	QLD	VIC/TAS	SA	WA
Accept	30	21	28	8	5
Undecided	16	12	15	16	10
Reject	54	53	55	21	27

Despite overwhelming rejection of the proposition, comparisons of responses with the presence or absence of service agreements, provides deeper insights into some of the influences on respondents' attitudes to this topic.

Across Australia those with formal agreements in place are no more likely to agree with the statement that hospitals work towards integrated services and care and involve residential care providers in continuity of care strategies, than respondents with no agreement or an informal one. The major feature in this group of responses is the level of disagreement across categories, and the levels of uncertainty expressed. While quite low, there appears to be less disagreement and more people unsure about whether hospitals are achieving this outcome if a formal agreement is in place.

Australia-wide agreements in place

"Acute hospitals work with aged care and government departments to deliver an integrated suite of services and care for older people across the acute hospital – residential aged care continuum"

			Agree	Disagree	Unsure	Total
Types of agreement between RACF and hospital	**None**	Count	33	82	25	140
		% category	23.6%	58.6%	17.9%	100.0%
		% of Total	8.9%	22.1%	6.7%	37.7%
	Formal	Count	5	9	8	22
		% category	22.7%	40.9%	36.4%	100.0%
		% of Total	1.3%	2.4%	2.2%	5.9%
	Informal	Count	51	118	36	205
		% category	24.9%	57.6%	17.6%	100.0%
		% of Total	13.7%	31.8%	9.7%	55.3%
	Both	Count	3	1	0	4
		% category	75.0%	25.0%	.0%	100.0%
		% of Total	.8%	.3%	.0%	1.1%
	Total	Count	92	210	69	371
		% category	24.8%	56.6%	18.6%	100.0%
		% of Total	24.8%	56.6%	18.6%	100.0%

23.1 New South Wales

NSW respondents have a quite negative view on this issue with only suburban respondents divided between agreement and disagreement. Country and regional centres are quite unambiguous in disagreeing with the proposition and metropolitan centres are also against it.

NSW

"Acute hospitals work with aged care and government departments to deliver an integrated suite of services and care for older people across the acute hospital – residential aged care continuum"

	Location of facility	Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	13	20	6	39
	% category	33.33	51.28	15.38	100.00
	% of Total	13.00	20.00	6.00	39.00

Large regional centre	Count	4	13	3	20
	% category	20.00	65.00	15.00	100.00
	% of Total	4.00	13.00	3.00	20.00
Small country town or village	Count	1	9	1	11
	% category	9.09	81.82	9.09	100.00
	% of Total	1.00	9.00	1.00	11.00
Outer suburbs of city	Count	12	12	6	30
	% category	40.00	40.00	20.00	100.00
	% of Total	12.00	12.00	6.00	30.00
Total	Count	30	54	16	100
	% category	30.00	54.00	16.00	100.00
	% of Total	30.00	54.00	16.00	100.00

23.2 Queensland

Queensland respondents are also strongly of the view that hospitals do not achieve this quality activity and almost 60% of metropolitan, regional and country centres disagree with the statement.

In suburban areas disagreement is more pronounced at over 70%. In every centre the proportion who are unsure is quite low compared with those who strongly express their views.

QLD *"Acute hospitals work with aged care and government departments to deliver an integrated suite of services and care for older people across the acute hospital – residential aged care continuum"*

Location of facility		Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	5	11	3	19
	% category	26.32	57.89	15.79	100.00
	% of Total	5.81	12.79	3.49	22.09
Large regional centre	Count	7	16	4	27
	% category	25.93	59.26	14.81	100.00
	% of Total	8.14	18.60	4.65	31.40
Small country town or village	Count	6	11	2	19
	% category	31.58	57.89	10.53	100.00
	% of Total	6.98	12.79	2.33	22.09
Outer suburbs of city	Count	3	15	3	21
	% category	14.29	71.43	14.29	100.00
	% of Total	3.49	17.44	3.49	24.42
Total	Count	21	53	12	86
	% category	24.42	61.63	13.95	100.00
	% of Total	24.42	61.63	13.95	100.00

23.3 South Australia

In South Australia only in large metropolitan centres did respondents take a relatively balanced view of hospital performance against this standard, and almost half of them are unsure as to whether hospitals are achieving these outcomes. A similar level of uncertainty can be seen below in the country town category despite so few declaring their agreement. Respondents from suburban and regional centres are quite sure about their disagreement with the statement.

SA *"Acute hospitals work with aged care and government departments to deliver an integrated suite of services and care for older people across the acute hospital – residential aged care continuum"*

	Location of facility	Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	5	5	9	19
	% category	26.32	26.32	47.37	100.00
	% of Total	11.11	11.11	20.00	42.22
Large regional centre	Count	1	6	1	8
	% category	12.50	75.00	12.50	100.00
	% of Total	2.22	13.33	2.22	17.78
Small country town or village	Count	1	3	4	8
	% category	12.50	37.50	50.00	100.00
	% of Total	2.22	6.67	8.89	17.78
Outer suburbs of city	Count	1	7	2	10
	% category	10.00	70.00	20.00	100.00
	% of Total	2.22	15.56	4.44	22.22
Total	Count	8	21	16	45
	% category	17.78	46.67	35.56	100.00
	% of Total	17.78	46.67	35.56	100.00

23.4 Victoria and Tasmania

Clearly respondents from Victoria and Tasmania are mostly of the view that hospitals are not achieving this quality outcome.

Strongest rejection of the proposition emerged from large metropolitan and regional centres as well as country towns.

Suburban area respondents are more likely to agree however the level of disagreement and uncertainty still dominates their attitudes towards hospital performance on this issue.

VIC/TAS *"Acute hospitals work with aged care and government departments to deliver an integrated suite of services and care for older people across the acute hospital – residential aged care continuum"*

	Location of facility	Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	10	21	4	35
	% category	28.57	60.00	11.43	100.00
	% of Total	10.20	21.43	4.08	35.71

Large regional centre	Count	2	7	3	12
	% category	16.67	58.33	25.00	100.00
	% of Total	2.04	7.14	3.06	12.24
Small country town or village	Count	6	15	4	25
	% category	24.00	60.00	16.00	100.00
	% of Total	6.12	15.31	4.08	25.51
Outer suburbs of city	Count	10	12	4	26
	% category	38.46	46.15	15.38	100.00
	% of Total	10.20	12.24	4.08	26.53
Total	Count	28	55	15	98
	% category	28.57	56.12	15.31	100.00
	% of Total	28.57	56.12	15.31	100.00

23.5 Western Australia

There is no doubt about the views of respondents from Western Australia. For the most part they disagree with the statement however in the outer suburbs there is fairly high uncertainty as to whether hospitals are achieving this quality outcome.

WA *"Acute hospitals work with aged care and government departments to deliver an integrated suite of services and care for older people across the acute hospital – residential aged care continuum"*

Location of facility		Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	3	14	4	21
	% category	14.29	66.67	19.05	100.00
	% of Total	7.14	33.33	9.52	50.00
Large regional centre	Count	1	7	1	9
	% category	11.11	77.78	11.11	100.00
	% of Total	2.38	16.67	2.38	21.43
Small country town or village	Count	0	0	1	1
	% category	0.00	0.00	100.00	100.00
	% of Total	0.00	0.00	2.38	2.38
Outer suburbs of city	Count	1	6	4	11
	% category	9.09	54.55	36.36	100.00
	% of Total	2.38	14.29	9.52	26.19
Total	Count	5	27	10	42
	% category	11.90	64.29	23.81	100.00
	% of Total	11.90	64.29	23.81	100.00

24 Hospital workforce involved with care of older people are skilled, responsive and in sufficient numbers

Interactions between staff of hospitals and aged care facilities form the basis upon which collaborative efforts can succeed in delivering high standards of care to older people who need to transfer between services. Where these interactions are strained or if any doubts exist regarding the competence or commitment of colleagues to the safe and effective care of older people, it is difficult to achieve true collaboration which is the basis for safe and effective care and treatment.

Question 34

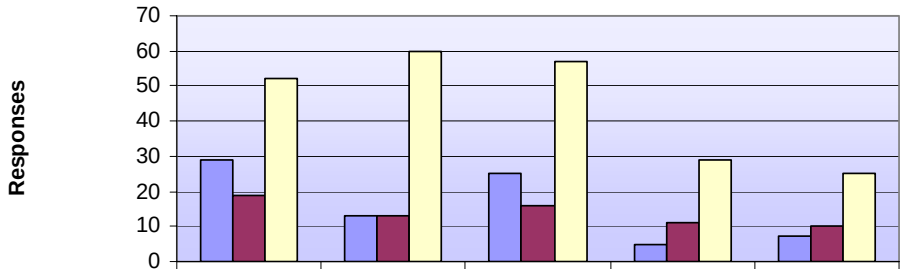
"Workforce involved in caring for older people are skilled, responsive and in sufficient numbers to meet older people's needs during transfers from hospital to residential aged care"

Respondent views:	Responses	% Responses
Strongly disagree	108	29.11
Mildly disagree	115	31.00
Neither agree nor disagree	69	18.60
Mildly agree	56	15.09
Strongly agree	23	6.20
Total Answers:	371	100.00

Respondents across Australia were asked to consider whether the hospital workforce they have encountered is skilled, responsive and in sufficient numbers to provide essential care during transfers. The answer was a resounding 'No'. 60.11% (n=223) of respondents either strongly or mildly disagree with this statement. Only 21.29% (n=79) agree and only a small number strongly agree that hospital staff can be described in such a positive way.

The State distribution chart below shows these respondent views.

The hospital workforce is skilled, responsive and in sufficient numbers to meet older people's needs during transfer to aged care



	NSW	QLD	VIC/TAS	SA	WA
Accept	29	13	25	5	7
Undecided	19	13	16	11	10
Reject	52	60	57	29	25

When compared with patterns of respondents' agreements with hospitals in the table below, those with formal agreements appear to have the greatest level of

unambiguous disagreement with the statement praising the hospital workforce in relation to care of older people.

Much depends on the elements of any agreements and whether these have any relationship to the concerns of aged care providers about care and treatment of their residents during hospital stays. Many comments provided by respondents in earlier sections contribute considerable evidence as to why respondents adamantly reject this statement.

Australia-wide agreements in place

"Workforce involved in caring for older people are skilled, responsive and in sufficient numbers to meet older people's needs during transfers from hospital to residential aged care"

			Agree	Disagree	Unsure	Total
Types of agreement between RACF and hospital	**None**	Count	29	83	28	140
		% within category	20.7%	59.3%	20.0%	100.0%
		% of Total	7.8%	22.4%	7.5%	37.7%
	Formal	Count	3	18	1	22
		% within category	13.6%	81.8%	4.5%	100.0%
		% of Total	.8%	4.9%	.3%	5.9%
	Informal	Count	44	121	40	205
		% within category	21.5%	59.0%	19.5%	100.0%
		% of Total	11.9%	32.6%	10.8%	55.3%
	Both	Count	3	1	0	4
		% within category	75.0%	25.0%	.0%	100.0%
		% of Total	.8%	.3%	.0%	1.1%
	Total	Count	79	223	69	371
		% within category	21.3%	60.1%	18.6%	100.0%
		% of Total	21.3%	60.1%	18.6%	100.0%

24.1 New South Wales

In NSW respondents from metropolitan and suburban centres are more likely than in other locations, to agree that hospital staff are skilled and in sufficient numbers to provide for the needs of older people during transfers to aged care. Country towns and regional centres are not seen by respondents as meeting these performance levels. In country towns all respondents are certain of their views on this matter

NSW *"Workforce involved in caring for older people are skilled, responsive and in sufficient numbers to meet older people's needs during transfers from hospital to residential aged care"*

Location of facility		Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	12	19	8	39
	% category	30.77	48.72	20.51	100.00
	% of Total	12.00	19.00	8.00	39.00
Large regional centre	Count	4	12	4	20
	% category	20.00	60.00	20.00	100.00
	% of Total	4.00	12.00	4.00	20.00
Small country town or village	Count	3	8	0	11
	% category	27.27	72.73	0.00	100.00
	% of Total	3.00	8.00	0.00	11.00
Outer suburbs of city	Count	10	13	7	30
	% category	33.33	43.33	23.33	100.00
	% of Total	10.00	13.00	7.00	30.00
Total	Count	29	52	19	100
	% category	29.00	52.00	19.00	100.00
	% of Total	29.00	52.00	19.00	100.00

24.2 Queensland

Large metropolitan and regional centre respondents from Queensland appear more likely to agree with the proposition that hospital staff are skilled and abundant, however most disagree. The remainder have doubts. Respondents from country towns and suburban areas are far from ambivalent in their disagreement with the suggestion that hospital staff can be accurately described in this way.

QLD *"Workforce involved in caring for older people are skilled, responsive and in sufficient numbers to meet older people's needs during transfers from hospital to residential aged care"*

Location of facility		Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	3	10	6	19
	% category	15.79	52.63	31.58	100.00
	% of Total	3.49	11.63	6.98	22.09
Large regional centre	Count	6	17	4	27
	% category	22.22	62.96	14.81	100.00
	% of Total	6.98	19.77	4.65	31.40
Small country town or village	Count	3	15	1	19
	% category	15.79	78.95	5.26	100.00
	% of Total	3.49	17.44	1.16	22.09
Outer suburbs of city	Count	1	18	2	21
	% category	4.76	85.71	9.52	100.00
	% of Total	1.16	20.93	2.33	24.42

	Count	13	60	13	86
	% category	15.12	69.77	15.12	100.00
Total	% of Total	15.12	69.77	15.12	100.00

24.3 South Australia

Respondents from South Australian country towns are quite unsure about this question however more were prepared to disagree than agree with the hospital workforce statement. In every other location their responses are clearly against the proposition and in the outer suburbs, no one at all could agree with it. The group most able to agree with the statement drawn from large regional centres.

SA

"Workforce involved in caring for older people are skilled, responsive and in sufficient numbers to meet older people's needs during transfers from hospital to residential aged care"

Location of facility		Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	2	14	3	19
	% category	10.53	73.68	15.79	100.00
	% of Total	4.44	31.11	6.67	42.22
Large regional centre	Count	2	5	1	8
	% category	25.00	62.50	12.50	100.00
	% of Total	4.44	11.11	2.22	17.78
Small country town or village	Count	1	2	5	8
	% category	12.50	25.00	62.50	100.00
	% of Total	2.22	4.44	11.11	17.78
Outer suburbs of city	Count	0	8	2	10
	% category	0.00	80.00	20.00	100.00
	% of Total	0.00	17.78	4.44	22.22
Total	Count	5	29	11	45
	% category	11.11	64.44	24.44	100.00
	% of Total	11.11	64.44	24.44	100.00

24.4 Victoria and Tasmania

The Victorian and Tasmanian respondent group presents a similar pattern to that of NSW in terms of suburban area levels of agreement. The other main groups likely to agree with the proposition are those from country towns where a similar level of disagreement is apparent along with much higher levels of uncertainty.

VIC/TAS

"Workforce involved in caring for older people are skilled, responsive and in sufficient numbers to meet older people's needs during transfers from hospital to residential aged care"

Location of facility		Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	8	26	1	35
	% category	22.86	74.29	2.86	100.00
	% of Total	8.16	26.53	1.02	35.71

Large regional centre	Count	1	8	3	12
	% category	8.33	66.67	25.00	100.00
	% of Total	1.02	8.16	3.06	12.24
Small country town or village	Count	6	12	7	25
	% category	24.00	48.00	28.00	100.00
	% of Total	6.12	12.24	7.14	25.51
Outer suburbs of city	Count	10	11	5	26
	% category	38.46	42.31	19.23	100.00
	% of Total	10.20	11.22	5.10	26.53
Total	Count	25	57	16	98
	% category	25.51	58.16	16.33	100.00
	% of Total	25.51	58.16	16.33	100.00

24.5 Western Australia

Western Australian respondents provide a clear impression of their views about hospital workforce quality. 61.90% from large metropolitan centres reject the idea and very few are uncertain. In regional areas no one could say they are in agreement. The location with the highest proportion of unsure respondents is the outer suburban category.

WA

"Workforce involved in caring for older people are skilled, responsive and in sufficient numbers to meet older people's needs during transfers from hospital to residential aged care"

	Location of facility	Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	6	13	2	21
	% category	28.57	61.90	9.52	100.00
	% of Total	14.29	30.95	4.76	50.00
Large regional centre	Count	0	6	3	9
	% category	0.00	66.67	33.33	100.00
	% of Total	0.00	14.29	7.14	21.43
Small country town or village	Count	0	0	1	1
	% category	0	0	100	100
	% of Total	0	0	2.38	2.38
Outer suburbs of city	Count	1	6	4	11
	% category	9.09	54.55	36.36	100.00
	% of Total	2.38	14.29	9.52	26.19
Total	Count	7	25	10	42
	% category	16.67	59.52	23.81	100.00
	% of Total	16.67	59.52	23.81	100.00

25 Families equipped by hospitals to provide support during transfers

There is a strong culture within the aged care industry of family sensitive care as well as advocacy on behalf of residents and their families. Families and aged care staff frequently work together to develop care approaches and quality of life enhancement strategies for residents and this does not cease when residents transfer to hospitals. Support of family members and efforts to prepare them for any eventualities that may arise from a hospital stay is part of the service provided by aged care staff.

Question 35

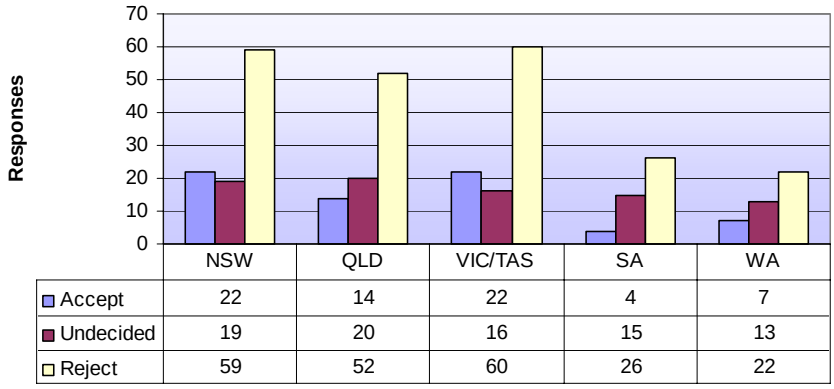
"Informal carers and family members are well equipped to provide support and care for older people during transfers from hospital to residential aged care."

Respondent views:	Responses	% Responses
Strongly disagree	97	26.15
Mildly disagree	122	32.88
Neither agree nor disagree	83	22.37
Mildly agree	53	14.29
Strongly agree	16	4.31
Total Answers:	371	100.00

When aged care staff were asked if they agreed that carers and families are well equipped by hospital staff to take up the care and support of older people as they transfer to aged care, again, the answer was 'no'. From the table above the large group who mildly disagreed could indicate that some effort is made by hospital staff to provide information and resources to families, however it is clearly not regarded as a best practice effort by the aged care staff who responded to this survey. Very few respondents could strongly agree and a relatively small group mildly agreed with the statement.

Response patterns across the different States shown below, demonstrate that few state hospital systems would be able to mount a convincing claim among aged care staff, that they are achieving this best practice outcome.

Carers and families are well equipped by hospital staff to provide support and care for older people during transfers to aged care



	NSW	QLD	VIC/TAS	SA	WA
Accept	22	14	22	4	7
Undecided	19	20	16	15	13
Reject	59	52	60	26	22

When compared with patterns of respondents' agreements with the statement about hospital performance in supporting families, shown in the table below, regardless of the type of agreement, there is significant disagreement with the proposition across all categories.

It is likely that any agreements whether formal or information would not include matters related to the support of families by hospital staff. Many comments provided by respondents about hospital dealings with families contribute considerable evidence as to why respondents adamantly reject this statement.

Australia-wide agreements in place

"Informal carers and family members are well equipped to provide support and care for older people during transfers from hospital to residential aged care."

			Agree	Disagree	Unsure	Total
Types of agreement between RACF and hospital	**None**	Count	22	83	35	140
		% within category	15.7%	59.3%	25.0%	100.0%
		% of Total	5.9%	22.4%	9.4%	37.7%
	Formal	Count	2	17	3	22
		% within category	9.1%	77.3%	13.6%	100.0%
		% of Total	0.5%	4.6%	0.8%	5.9%
	Informal	Count	43	117	45	205
		% within category	21.0%	57.1%	22.0%	100.0%
		% of Total	11.6%	31.5%	12.1%	55.3%
	Both	Count	2	2	0	4
		% within category	50.0%	50.0%	0.0%	100.0%
		% of Total	0.5%	0.5%	0.0%	1.1%
	Total	Count	69	219	83	371
		% within category	18.6%	59.0%	22.4%	100.0%
		% of Total	18.6%	59.0%	22.4%	100.0%

25.1 New South Wales

In NSW respondents from regional and suburban centres are more likely than in other locations, to agree that hospital staff equip families to provide support to older people during transfers to aged care. Across all centres respondents do not believe hospitals meet this performance level.

NSW *"Informal carers and family members are well equipped to provide support and care for older people during transfers from hospital to residential aged care."*

Location of facility		Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	7	24	8	39
	% category	17.95	61.54	20.51	100.00
	% of Total	7.00	24.00	8.00	39.00
Large regional centre	Count	4	11	5	20
	% category	20.00	55.00	25.00	100.00
	% of Total	4.00	11.00	5.00	20.00
Small country town or village	Count	1	8	2	11
	% category	9.09	72.73	18.18	100.00
	% of Total	1.00	8.00	2.00	11.00
Outer suburbs of city	Count	10	16	4	30
	% category	33.33	53.33	13.33	100.00
	% of Total	10.00	16.00	4.00	30.00
Total	Count	22	59	19	100
	% category	22.00	59.00	19.00	100.00
	% of Total	22.00	59.00	19.00	100.00

25.2 Queensland

Outer suburban respondents from Queensland appear more likely to disagree with the proposition that hospital staff equip families to deal with this situation, however most other centres also disagree. Around one in four respondents in all areas are unsure about the proposition.

QLD *"Informal carers and family members are well equipped to provide support and care for older people during transfers from hospital to residential aged care."*

Location of facility		Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	4	10	5	19
	% category	21.05	52.63	26.32	100.00
	% of Total	4.65	11.63	5.81	22.09
Large regional centre	Count	5	16	6	27
	% category	18.52	59.26	22.22	100.00
	% of Total	5.81	18.63	6.98	31.40
Small country town or village	Count	5	10	4	19
	% category	26.32	52.63	21.05	100.00
	% of Total	5.81	11.63	4.65	22.09
Outer suburbs of city	Count	0	16	5	21
	% category	0.00	76.19	23.81	100.00
	% of Total	0.00	18.60	5.81	24.42

	Count	14	52	20	86
	% category	16.28	60.47	15.12	100.00
Total	% of Total	16.28	60.47	23.26	100.00

25.3 South Australia

Half the respondents from South Australian suburban centres and country towns disagree with the proposition that hospital achieve this outcome for families however large regional centres are regarded as not achieving it at all.

SA *"Informal carers and family members are well equipped to provide support and care for older people during transfers from hospital to residential aged care."*

Location of facility		Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	2	8	9	19
	% category	10.53	42.11	47.37	100.00
	% of Total	4.44	17.78	20.00	42.22
Large regional centre	Count	0	7	1	8
	% category	0.00	87.50	12.50	100.00
	% of Total	0.00	15.56	2.22	17.78
Small country town or village	Count	1	4	53	8
	% category	12.50	50.00	37.50	100.00
	% of Total	2.22	8.89	6.67	17.78
Outer suburbs of city	Count	1	7	2	10
	% category	10.00	50.00	20.00	100.00
	% of Total	2.22	15.56	4.44	22.22
	Count	4	26	15	45
	% category	8.89	57.78	33.33	100.00
Total	% of Total	8.89	57.78	33.33	100.00

25.4 Victoria and Tasmania

The Victorian and Tasmanian respondent group clearly disagree with the proposition and the next largest category is in the outer suburbs.

VIC/TAS *"Informal carers and family members are well equipped to provide support and care for older people during transfers from hospital to residential aged care."*

Location of facility		Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	68	26	3	35
	% category	17.14	74.29	8.57	100.00
	% of Total	6.12	26.53	3.06	35.71
Large regional centre	Count	2	6	4	12
	% category	16.67	50.00	33.33	100.00
	% of Total	2.04	6.12	4.08	12.24

Small country town or village	Count	7	13	5	25
	% category	28.00	52.00	20.00	100.00
	% of Total	7.14	13.27	5.10	25.51
Outer suburbs of city	Count	7	15	4	26
	% category	26.92	57.69	15.38	100.00
	% of Total	7.14	15.31	4.08	26.53
Total	Count	22	60	16	98
	% category	22.45	61.22	16.33	100.00
	% of Total	22.45	61.22	16.33	100.00

25.5 Western Australia

Western Australian respondents provide a clear impression of their views about whether hospital staff equip families to cope with resident transfers. 66.67% from large regional centres reject the idea and none agree that it occurs. In small country towns hardly any responses were received. The location with the highest proportion of unsure respondents is the outer suburban category.

WA *"Informal carers and family members are well equipped to provide support and care for older people during transfers from hospital to residential aged care."*

Location of facility		Agree	Disagree	Unsure	Total
Large metropolitan centre	Count	6	13	2	21
	% category	28.57	61.90	9.52	100.00
	% of Total	14.29	30.95	4.76	50.00
Large regional centre	Count	0	6	3	9
	% category	0.00	66.67	33.33	100.00
	% of Total	0.00	14.29	7.14	21.43
Small country town or village	Count	0	0	1	1
	% category	0	0	100	100
	% of Total	0	0	2.38	2.38
Outer suburbs of city	Count	1	6	4	11
	% category	9.09	54.55	36.36	100.00
	% of Total	2.38	14.29	9.52	26.19
Total	Count	7	22	13	42
	% category	16.67	52.38	30.95	100.00
	% of Total	16.67	52.38	30.95	100.00

26 Summary and recommendations

Aged care providers work to achieve compliance with quality principles as expressed in 44 outcomes themed under four broad standards covering management, care, environment and lifestyle. All outcomes must be met and audited in order to meet accreditation requirements and continue to receive government funding. It is not unrealistic to expect other government subsidised organisations providing services to older people to apply themselves to achieving similar quality outcomes for their facility. Hospitals are increasingly involved with acute care and treatment of older people as well as providing the primary access pathway for people wishing to access residential aged care. Perhaps it is time for quality standards to be introduced across the care continuum so that all involved are accountable.

Three major statements of standards and principles for hospital involvement with older patients and residential care clients were published in 2004 and provide a solid basis for comparison of standards of care, management and quality performance. These three reports have been applied in this survey to gauge the quality of care being provided by hospitals to residents while in hospital and during transfers.

The views of 371 senior respondents from aged care provide a type of report-card on hospitals they have dealt with … and the report is quite damning. Only with considerable effort and optimism have we been able to extract positive interpretations for each of the statements or standards.

Some States are performing better than others and in NSW this is the case across most of the standards chosen. However views altered with different locations as they did for all States, and it would be wise for hospitals in these locations to listen to this feedback from a major client group of their service.

26.1 Recommendations

Aged care standards apply to all who care for older people. Hospitals undergo management-focused accreditation however hospital care standards revealed through this survey need urgent attention and could benefit from participating in quality reviews aligned with aged care.

The results of this survey be used at State and local regional level to prompt greater communication and closer liaison between hospitals and aged care providers.