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EXECUTIVE SUMMARY

FOR THEIR SAKE

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

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1 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 foreward is also proposed. These are summarised in the next section.

2 Recommendations

2.1 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.

2.1.1 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.

2.2 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.

2.2.1 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.

2.3 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.

2.3.1 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.

2.4 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.

2.4.1 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.

2.5 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 instance 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.

2.5.1 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.

2.6 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.

2.6.1 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.

2.7 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.

2.7.1 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.

2.8 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.

2.8.1 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.

2.9 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.

2.9.1 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.

2.10 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.

2.10.1 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.

2.11 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.

2.11.1 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.