Aged care - Right intervention, right time

One of the greatest challenges facing the health system today, is meeting the healthcare needs of our aging population. The most recent Census data shows that the number of people aged 65 years and over continues to increase. In addition, since 2006 there has been a 29.4% increase in the number of people aged 85 years and over.[1] How best to care for this often vulnerable sector of our population – with all their associated health needs – is a matter that the health system, as well as many individual health practitioners, will increasingly need to address.

An issue that has featured several times recently in complaints to the HDC is the role of general practitioners in rest homes. Though many may think of rest homes as primarily being the domain of nursing staff and care assistants, GPs also play an important role in this setting. One of the Commissioner's main focuses has been on ensuring the provision of seamless services – different providers working together to ensure continuity of care for the patient. This is particularly relevant for GPs working in rest homes. Two recent opinions issued by the HDC demonstrate the importance of GPs working in a coordinated way with other providers in that setting.

In the first case,[2] an 84 year-old woman was admitted to a rest home with a number of health issues including Parkinson's disease, diabetes, and osteoporosis. She was assessed as being at very high risk of pressure injuries, and during her time at the rest home developed several pressure sores. The woman was reviewed by a GP on a regular basis, and when acute issues (such as pressure sores) arose.

The woman developed a sacral pressure sore, which was managed by the home's nursing staff and initially improved with treatment. However, over the next few months the sore deteriorated. The GP assessed the woman four times over that period, but was not made aware of, and so did not assess, the sore until six months after it was initially noted. At that point, the GP took a wound swab for laboratory testing and recorded his plan to review the woman again in a week.

The following week, the GP reviewed the test results and advised the rest home nurse assisting him that the woman did not require antibiotics. However, the GP did not review the woman as he had planned. The GP told HDC that he did not do so because the nurse did not place the file on the ward-round trolley, and did not remind him of his plan to review the woman. The next day one of the home's nurses requested that the GP make an urgent referral to the local public hospital because of the deteriorating state of the woman's sore which was by then oderous, oozing and necrotic. Once the woman was admitted to hospital, a decision was made in conjunction with her family to provide palliative care only. The woman died a short time later.

The Commissioner's investigation of this complaint identified a number of failures by nursing staff and by the rest home in their management of the woman. While acknowledging that the GP had relied on nursing staff to bring issues to his attention, the Commissioner was nevertheless concerned that, given the seriousness of the sore, the GP did not assess it again the week following his initial assessment.

In another case,[3] family members complained to the HDC about the care provided to an elderly woman living in a serviced apartment in a retirement village. The village did not provide rest home or hospital level care, and required residents to be able to live independently. The village, however, did offer some limited nursing care, employing two registered nurses to provide daily clinics and

[1] http://www.stats.govt.nz/Census/2013-census/profile-and-summary-reports/quickstats-about-national-highlights/age-and-sex.aspx
[2] 11HDC00471. Available at www.hdc.org.nz
[3] 12HDC00555. Available at www.hdc.org.nz

emergency on-call assistance. A local GP also held a weekly clinic at the village. Most residents enrolled with the GP's practice and, if they needed to be seen outside the weekly clinic, they could make an appointment at the practice. The GP and the village nurses worked largely independently from one another – for example, results of tests ordered by the GP were sent to the practice and were not routinely passed to the village nurses.

A few months after moving to the village and registering with the GP's practice, the woman attended the weekly clinic for a routine check up. The GP ordered a variety of tests including a non-fasting glucose test. That test returned an abnormal result showing that the woman was at high risk of diabetes. The pathology report recommended further tests, in particular a fasting glucose test. The GP arranged further tests, but did not arrange a fasting glucose test. The second round of tests also returned abnormal results, with the pathology report again recommending further tests. The GP did not organise any further tests, and did not inform the woman of the results.

Over the next eighteen months the woman had seven further interactions with the GP relating to a variety of health issues. On none of these occasions did the GP inform the woman of her abnormal test results, or take any follow-up action relating to those results. Approximately eighteen months after the initial consultation, the GP ordered blood tests which again showed an abnormal glucose level. Once again, the pathology report recommended further tests to diagnose diabetes. The GP did not organise or carry out any follow-up, and no diagnosis was made.

Later that month, one of the village nurses contacted the GP about the woman's declining health, and asked him to organise a needs assessment. Prior to the assessment, the GP ordered further blood tests. The results were returned two days before the assessment, and were again abnormal. The pathology report confirmed a diagnosis of diabetes. Two days later, the needs assessor recommended admission to hospital for a full medical review. The woman was admitted and diagnosed with diabetes, which hospital staff noted had not been adequately managed in the community.

After a thorough investigation, the Deputy Commissioner found that the GP's communication and clinical management failures had led to a significant delay in the woman's diagnosis, and therefore had delayed her access to treatment. The failures were all the more serious because they were repeated. In addition, the GP's failure to inform the woman of her results deprived her of the opportunity to be an effective partner in her own healthcare. Because of the serious nature of his failures, the GP has been referred to the Director of Proceedings.

The above cases are just two examples, but demonstrate the importance of communication in aged care, with its multidisciplinary approach and patients who may not be able to advocate for themselves. Seamless service in such an environment requires providers to communicate information to all members of the healthcare team so that everyone is "on the same page" - alert to developing issues, and aware of how to manage them. But it also requires providers to take responsibility for their own role and responsibilities as a member of that healthcare team, and to not rely entirely on others to prompt them to action. Such an approach is likely to assist in ensuring that patients are provided with the right interventions at the right time.

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