Complaints to the Health and Disability Commissioner about Residential Aged Care Facilities: Analysis and Report 2010-2014

New Zealand's long-term aged care support is dominated by residential aged care facilities (RACFs) with around 31,000 older people currently residing in RACFs.

Similar to other OECD nations, New Zealand's aging population is growing which is placing, and will continue to place pressure on health and disability providers supporting this population group.

Health and Disability Commissioner (HDC) has recently published an in-depth topical analysis of HDC's complaint data about RACFs: "Residential Aged Care. Complaints to the Health and Disability Commissioner: 2010-2014**.**" This report, published on HDC's website (http://www.hdc.org.nz/media/300644/residential%20aged%20care%20report.pdf), presents an analysis of the issues raised in complaints made to HDC about RACFs, and takes an in-depth look at the trends in complaints regarding:

- communication with families;
- communication between providers;
- hygiene issues;
- fluid/nutrition;
- pain management;
- falls;
- wound care; and
- the recognition and management of deteriorating conditions.

As well as identifying key issues in complaints, this report brings together the recommendations made by HDC in the above areas, with a view to improving quality of care.

Complaints regarding communication between residential aged care facility staff and GPs

Older people entering RACFs are often presenting with complex needs, multiple co-morbidities and at a later stage of illness. This demands a higher level of care and skill from facilities than may have been in the case in the past and creates a further imperative to ensure quality service delivery.

In New Zealand, RACFs are dependent on GPs to provide medical assessment and primary care intervention. GPs, in turn, are often reliant on RACF staff to alert them to any changes in residents' conditions or the need for intervention, including referral to secondary care. Therefore, good communication and coordination of care between providers is crucial to the provision of quality care to residents in these facilities.

Inadequate communication between providers was the second most commonly complained about issue in complaints about RACFs, being at issue in 33% of cases. These complaints most often related to communication between RACF staff and GPs. Complainants were often concerned that a GP had not been adequately informed of the resident's changing condition or of an adverse event, or that RACF staff had not adequately followed the GP's recommendations or treatment plan. Such complaints also arose in relation to concerns about the timeliness of GP intervention.

Complaints regarding inadequate communication between facility staff and GPs were also a feature of complaints involving the management of a resident's risk for malnutrition/dehydration, post-fall assessments, wound prevention and treatment, and the

recognition/management of deteriorating conditions. This further highlighted the important role GPs play in the clinical care of residents and the importance of facility staff keeping GPs informed of any changes in the resident's condition.

Because GPs are often reliant on facility staff to notify them of changes in the residents' conditions, it is important that facilities have robust policies and procedures around when a resident's care needs to be escalated for GP review and what information needs to be communicated to the GP. Facilities also need to have good systems around the scheduling of prompt GP appointments and follow-up. Additionally, facilities are required to ensure that GPs enter findings, and any treatment given to, or ordered for, the resident, into the relevant clinical records maintained on site at the time of the GP's attendance. This is important for ensuring that the GP's recommendations and treatment plans are communicated to, and followed by, facility staff.

This environment, where residents can have high levels of dependency and may not be able to advocate for themselves, requires all members of the healthcare team to be aware of any developing issues and how these issues are being managed. Although it is important that this information is communicated effectively, it is also important that providers take responsibility for their own role in the provision of care, and not rely entirely on other providers to prompt them to action.

Some examples of recommendations HDC has made to facilities when deficiencies have been identified in communication between facility staff and GPs, include asking facilities to:

- develop a policy relating to the process for escalating a concern to the contracted GP or after hours provider, including in-house training on the policy;
- remind nursing staff of the importance of keeping GPs fully informed about a patient's condition and any family concerns – particularly residents who have limited communication and may not be able to communicate adequately;
- review their policies and procedures to ensure timely contact and follow-up of GPs and conduct a review of the effectiveness of the changes made;
- provide training to staff around when care needs to be escalated to a resident's GP following a fall;
- amend their wound care management policy regarding the management of pressure areas to ensure that all wounds of two months or longer are reviewed by a wound specialist or GP; and
- provide training to RNs to help them become more assertive when discussing their concerns about a resident's condition with the GP.

There are important lessons to be learnt from the trends and patterns that emerge from the analysis of complaint data referred to HDC. I trust the information presented in HDC's published report will prove useful to the providers of residential aged care services, and will help to improve the quality of care.

Rose Wall, Deputy Health and Disability Commissioner
with assistance from **Natasha Davidson, Senior Advisor, Research and Education**

NZ Doctor
September 2016