

Mary's journey

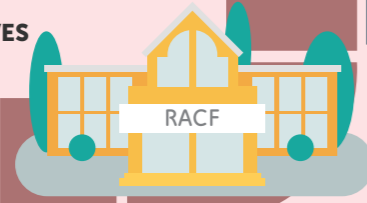
Mary is a Gold Coast local with three children; one (John) who lives in Brisbane, while the others live interstate. Mary's husband died 5 years ago, after which she decided with the help of her family to move into a Residential Aged Care Facility (RACF). Mary suffers from heart failure and several other co-morbid conditions. She requires some support to shower and needs a wheelchair to move long distances. She was previously active with a local craft group but hasn't seen them since moving into the RACF.

Mary is 92 and has lived in a RACF on the Gold Coast Northern Region for 5 years



MARY MOVES INTO RACF

Hospital: Mary often cancels her specialist appointments at the hospital as she feels she is being a burden by needing a staff member to help transport her in her wheelchair.



Mary: Mary has feelings of sadness and isolation as she becomes disconnected from her local community due to moving into a RACF from the South Region of Gold Coast. As a Catholic, Mary enjoys attending church weekly and meeting with the visiting pastoral care volunteers and delta dog visit all at the RACF.

MARY HAS A FALL

GP: Mary had to change GPs when she entered RACF as her existing GP did not visit the area. Her new GP is unable to provide after-hours visits.

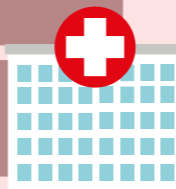
Ambulance: Mary is transferred to the Robina Hospital emergency department (ED) by Queensland Ambulance Service.

Hospital: Mary waits in ED for 3 hours for a review. The ED team is extremely busy and Mary is triaged as a low priority. She waits on a bed by herself, is provided pain relief and a nurse pops past regularly to check on her. At the 3-hour mark, the doctor is reminded that she has been there for 3 hours and quickly orders scans, provides medicine and organises admission to a general medical ward.

Mary: Mary has a fall at her RACF on a Friday at 8pm. She is found on the bathroom floor by another resident who heard her yelling around half an hour later. Mary didn't have her call bell around her neck and couldn't reach the wall call bell. She waits on the floor for 45 minutes with a carer.

RACF Nurse: The on-call registered nurse (RN) is called to the RACF for review and arrives after another 45 minutes. The RN calls an ambulance as it appeared she has a fractured hip and is experiencing severe pain.

Mary is triaged as low priority and waits for 3 hours in ED

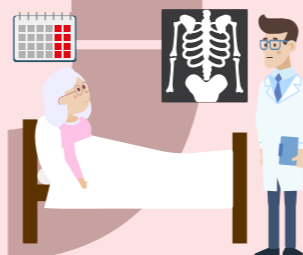


MARY REQUIRES SURGERY

RACF: The RACF Manager organises an assessment of Mary's needs to be done to seek additional funding for her increased care needs. An Activities Coordinator brings some music and organised for Delta dogs to visit.

Hospital: The ambulance arrived quickly to transfer Mary back to the RACF so hospital staff didn't have a chance to chat to Mary about Goals of Care or Advance Care Planning.

Doctor: Mary's doctor tries to decide on the best way forward – to operate or treat conservatively? As Mary has no cognitive issues she is able to make the decision herself, but it's a difficult conversation to have.



Mary returns to the RACF, where she is largely confined to her room at the end of a hallway, rarely seeing other residents and unable to go to activities. She experiences increasing feelings of isolation. Mary deteriorates quickly and requires assistance for feeding in her bed, but staff struggle to get there and she often tries to feed herself "to save them time".

MARY RETURNS TO RACF

RACF: The discharge nurse hands Mary's case over to the RACF Manager. Mary's needs have changed, now requiring a high level of care placing further burden on the RACF's limited staffing and available equipment.

Family: Her family is concerned that she won't receive the care she requires if she returns and becomes 'bed bound'.

Mary: Mary decides she doesn't want the operation, as she has lived a good life and would rather just go back to her residence to have conservative treatment.

Mary is in a single room in the general ward waiting on surgery for her fractured hip. Doctors are concerned that due to her age and her heart condition she "might not make it". She does not have an advance care plan as her family have struggled to talk about dying with her husband's quick death 5 years ago.

Mary's care transitions from curative care to palliative care.

GP: Mary's GP is unavailable to visit until two days after she returns from hospital. Mary is reviewed by her GP and is diagnosed with aspiration pneumonia. She is treated with antibiotics which has limited effect, after which her GP informs staff that she is palliative.

Priest: The RACF priest visits Mary to attend to her spiritual needs.

Family: Mary's son John visits as much as possible, while her other family make arrangements to visit from interstate.

MARY'S CONDITION DECLINES

Mary: Mary is increasingly drowsy, has increased pain and restlessness and is provided a syringe driver by her GP. At midnight Mary begins screaming in pain, and becomes increasingly restless, as the syringe driver battery has run out.

RACF: The RACF staff assist John and family to clean out her room but become aware how angry the family are, overhearing them talk about the "bad care she received". The RACF priest provides support to the other residents who knew Mary.

Mary's family is very angry about her death and they receive no formal debrief.

Family: Mary's family are grieving, they are not given any formal debrief. Mary's children attend the funeral. They all remain very angry with what happened.

Hospital: The funeral directors provide support to John and his family.

A BEREAVED FAMILY

Hospital: ED staff give Mary and her son John a private room and a social worker sits with them. Mary dies in ED 3 hours later.

Ambulance: Ambulance arrives and takes Mary back to the ED.

RACF: The only RN is at another facility assisting with a fall and is unable to get there within the hour, so RACF staff call an ambulance. Mary is without pain relief for at least 3 hours.

Key Themes:

- People often have to relocate from their communities to access a RACF that has a vacancy
- Limited capacity for RACF staff to respond in a timely way to resident emergencies such as falls
- Limited capacity for RACF to respond and resource timely high care needs
- Unnecessary emergency presentation
- Lack of bereavement support
- Queensland hospital emergency departments have a 4-hour target to get people seen, treated and exited from emergency