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Emergency department transfers from residential aged care: what can we learn from secondary qualitative analysis of Australian Royal Commission data?

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ABSTRACT

Objectives To use publicly available submissions and evidence from the Australian Royal Commission into Aged Care Quality and Safety as data for secondary qualitative analysis. By investigating the topic of emergency department transfer from the perspective of residents, family members and healthcare professionals, we aimed to identify modifiable factors to reduce transfer rates and improve quality of care.

Design The Australian Royal Commission into Aged Care Quality and Safety has made over 7000 documents publicly available. We used the documents as a large data corpus from which we extracted a data set specific to our topic using keywords. The analysis focused on submissions and hearing transcripts (including exhibits). Qualitative thematic analysis was used to interrogate the text to determine what could be learnt about transfer events from a scholarly perspective.

Results Three overarching themes were identified: shortfalls and failings, reluctance and misunderstanding, and discovery and exposure.

Conclusions The results speak to workforce inadequacies that have been central to problems in the Australian aged care sector to date. We identified issues around clinical and pain assessment, lack of consideration to advance care directives and poor communication among all parties. We also highlighted the role that emergency departments play in identifying unmet clinical needs, substandard care and neglect. Given the inadequate clinical care available in some residential aged care facilities, transferring residents to a hospital emergency department may be making the best of a bad situation. If the objective of reducing unnecessary transfers to emergency departments is to be achieved, then access to appropriate clinical care is the first step.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ The evidence made publicly available by the Royal Commission into Aged Care Quality and Safety presented a unique opportunity for scholarly qualitative research.
⇒ The data used for this analysis represent big qualitative Australian aged care data and included the voices of older people, family members, the aged care workforce, care providers and health professionals.
⇒ The focus of the Royal Commission selection of evidence was focused on substandard care and abuse within a legalistic framework.
⇒ Using secondary data limits the scope of the voices present in the data and restricts the qualitative analysis to post hoc research questions.

INTRODUCTION

Older people live in residential aged care facilities (RACF) because they have complex clinical health requirements, including multimorbidity, polypharmacy, cognitive decline and functional impairment. From time to time these conditions may require acute care.[1 2] In addition, adverse events such as fall-related trauma, medication errors, infection, pressure ulcers, dehydration, cardiac events and pneumonia also require acute medical attention that often result in transfer to a hospital emergency department (ED).[1 3] In Australia, one-third of RACF residents had at least one transfer to ED during 2018–2019.[4] An Australian study showed that between 2009 and 2013 transfers from RACFs to ED occurred at rates four times higher than those for older people living at home, illustrating the higher care needs of this vulnerable population.[5]

RACF transfers to a hospital ED provides vital acute care when necessary. However, not all transfers to ED are considered appropriate. In a systematic review of ED transfers from RACFs internationally, up to 55% were considered avoidable, meaning that clinical care in the residential facility should have been possible and would have been preferable to care in an acute setting.[2] Transfer may also be deemed avoidable or preventable where suboptimal conditions in a facility have contributed to the condition requiring attention.[6] International reviews also suggest that some emergency transfers do not improve quality of life or increase life expectancy and may in fact be detrimental to both.[7 8] ED transfers may present an unnecessary burden to

the resident, resulting in invasive interventions, increased risk of delirium and hospital-acquired infections.[7] Time spent in an ED may also interrupt usual care provision, including palliative care.[9] Australian rates of emergency transfers vary between RACF's suggesting modifiable patient and organisational risk factors and may be indicative of poor-quality care.[10]

Following the Oakden Report[11] and a national broadcast that publicly exposed poor care within the Australian aged care sector,[12] the Australian Governor General established a Commonwealth public enquiry in the form of a Royal Commission into Aged Care Quality and Safety (RC) in 2018.[13] The terms of reference for the RC included 'the quality of aged care services, the prevalence of substandard care including abuse, the causes of any systemic failures in aged care and actions that should be taken in response'.[14] Regarding ED transfers, the RC Final Report recommended improving communication between facilities and hospitals, implementing a digital management system, and creating multidisciplinary outreach services managed by local hospitals.

Our aim was to re-examine the evidence from the RC using a scholarly, rather than the legalistic lens, to identify and describe additional aspects of ED transfer that could improve policy and impact practice. A critical realist epistemology[15] underpinned our method and analysis. Critical realism recognises the role that the social construction of the 'older person' plays in the lived experience of residents in RACFs. While our analysis was aimed at identifying opportunities for practical improvement, we also wanted to centre attention on how the constructed representations of older people can contribute to the practices requiring attention.

METHOD

The RC received over 10 000 submissions from the public, aged care providers, health professionals and special interest groups, most of which are publicly available on the RC website.[13] The data we included for analysis consisted of all available items of the following type: general submissions (1183 items), hearing transcripts and posthearing submissions (227 items), exhibits (5712 items) and commissioner reports (17 items). In total, we downloaded 11 GB of data. All publicly available data were previously vetted and redacted by the RC and it is on this process that we have to assume quality appraisal. We attributed equal importance to all data, regardless of source.

In performing qualitative analysis on a dataset of this size, it was not feasible to move straight into inductive coding. Instead, we proceeded with 'economy of effort'.[16] Our approach to data analysis data was informed by Davidson *et al*'s[16] iterative breadth and depth method and Seale and Charteris-Black's[17] approach to keyword analysis. Both approaches offer practical techniques for 'Big' qualitative data. We compiled a detailed list of 102 keywords relating to ED transfers from RACF's. Keywords were based on the extant literature and author expertise and included terms such as, ambulance, 'ED', hospital, fall, doctor, together with their abbreviations and Boolean terms. Keyword searches were conducted using NVivo.[18] Search outcomes were reviewed for relevance and content was isolated to create a topic-specific data set incorporating content from all available sources.

To capture the experience of the transfer incident, we focused on material representing the experience of residents, family, care workers and health professionals, all voices were given equivalent priority during analysis. Due to the size of the data, two levels of coding were conducted. First, data were deductively coded for relevant content across 62 descriptive codes. The data were then reread and inductively coded using Thematic Analysis[19] into 28 thematic codes with potential themes and extracts identified. During the thematic coding, we paid attention to the dominant and to the more nuanced findings. Throughout, the thematic structure was reviewed and discussed between all authors to identify, refine and define our themes. Extract reporting follows the ethical guidelines of the Association of Internet Researchers,[20] with names of persons and organisations omitted from extracts.

Patient and public involvement

This project used publicly available secondary data; no participants were recruited for the purpose of the study. The study design and research question development did not involve public or patient consultation.

RESULTS

Through analysis of the data, we identified three overarching themes; shortfalls and failings, reluctance and misunderstanding, and discovery and exposure. Our thematic findings extend beyond identifying factors relating to avoidance to focus on events surrounding ED transfers more broadly. To support our thematic interpretation, we include extracts from general submissions, exhibits and hearing transcripts.

Shortfalls and Failings

Reports on lack of clinical care and failings in communication between RACFs and ED's were frequent in the data. The following extracts show that RACF care workers and paramedics alike spoke of concerns relating to ED transfers due to shortfalls in clinical care and appropriate end of life care, and shortfalls in staffing more generally.

> …quite often patients will be sent into hospital because the staff are just lacking confidence, skill, and experience in basic assessments of patients. (Paramedic; hearing transcript)

> I also believe that because palliative care was not adequately provided at [facility name] my father was transferred into hospital. I believe this is inhumane

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and unnecessary, and an unnecessary thing to do at end of life. (Family member; hearing transcript)

…a lot of the calls that we get will be throughout the night and on weekends, when there aren't GPs and other health networks available. There's also limited staffing on …which makes ambulance the primary option for health care. (Paramedic; hearing transcript)

Health professionals also reported that failings in communication between RACFs and EDs impacted both acute and ongoing care. Paramedics expressed concerns and challenges about the quality and quantity of information provided by residential facilities. Evidence suggested that poor communication went both ways, as the following extracts indicated.

…it has happened more than once where I've loaded the patient onto the stretcher, another staff member has entered…and said "…that resident is not the patient…" (Paramedic; hearing transcript)

I was sent back to the facility from hospital with only two tablets of medication. There were no medical notes sent back … I was told that the records had been sent to another hospital … it took a week or two for the facility to receive my medical file. (Resident; general submission)

Additionally, family members expressed concerns about being left out of decisions to transfer (or not transfer). Even the presence of an advance care directive (ACD) was not enough to enact the wishes of a resident and/or their family.

… they would call me in the morning to say 'We had to call them again [the ambulance], but she's back, and everything seems ok.' (Family; hearing transcript)

… even when a person has an ACD it is often the case that staff do not check them and when a patient is transferred between facilities, the ACD doesn't go with them. (Paramedic; general submission)

This theme reflected the types of concerns raised in the recommendations from the RC. The absence of an adequately skilled workforce to provide clinical care and end of life care meant that residents were often sent to an ED. Shortfalls in staffing also appeared to impact communication, influencing the quality of information recorded and capacity to check resident records.

Hesitancy and misunderstanding

Our first theme identified how clinical care shortfalls contribute to ED transfers. Our second theme extended our focus beyond the topic of avoidable transfers to highlight issues surrounding decisions not to transfer residents. The following extracts highlight workforce reluctance to engage services where acute care appeared required, and alternative care was not forthcoming. Extracts showed how RACF staff were unable to make accurate assessments of clinical need, which then resulted in family intervention.

Dad was having chest pains … and he said he'd been having them pretty much consistently for two days … he felt like he was having a heart attack … staff were assuring him that he was not having a heart attack and that he was anxious and paranoid … I took dad myself to the GP clinic … the GP immediately called the ambulance … he was having a heart attack. (Family member; hearing transcript)

I knew there was something—that pain was so intense … one of the physios came in and said, 'It's all in your head, there's nothing wrong.' My friends said, 'If you don't get [resident's name] to hospital, you will be guilty of elder abuse.' … within half an hour the ambulance was here, and sure enough, I had a crushed disc and a broken back. (Resident; hearing transcript)

I said, 'I want a doctor to see her, other than that I need an ambulance to take her to hospital.' … the RN [registered nurse] said to me 'he's not urgent. There's not a lot wrong with her.' I don't know how they could have assessed that without even getting a stethoscope out … she went to the hospital on the Saturday. And on the Sunday an emergency doctor at[facility's name] rang me to say she had two to 48 hours to live. (Family member; hearing transcript)

On many occasions, families and residents described how attending staff failed to make accurate pain assessments. The instances above described how pain was dismissed and clinical care delayed. The following extracts illustrate how residents' pain was misunderstood due to cultural and cognitive factors.

I believe if the staff that night would have communicated with Mum by using a bi-cultural poster and pain scale … we could have saved her. They misunderstood her tears just for loneliness and attention seeking, not for pain. They didn't call the ambulance or me or anybody … (Family member; hearing transcript)

Because of Mum's dementia she wasn't able to display any normal pain responses. The doctor at the hospital was shocked by the condition of the wound and couldn't believe Mum hadn't been brought in earlier. The wound was down to the bone and was significantly infected. I was told it would have been causing Mum a great deal of pain. (Family member; exhibit)

In some cases, staff inaction appeared related to indifference or poor attitude, while in other cases inaction appeared a consequence of inexperience. Negative attitudes towards older people, or ageism[21] is complex and can be more pronounced in healthcare contexts[22] and negatively impact treatment quality.[23] In this theme, we have evidence of residents unable to advocate for their own needs and denied appropriate care. Reluctance to engage acute services may be rooted in a deeper problem than aged care workforce supply and training, it may point to the fundamental societal problem of ageism.

Discovery and exposure

The apparent lack of clinical care available to many aged care residents meant that transfer to an ED provided opportunity to identify and manage unmet clinical needs. This included previously unknown or underlying medical conditions or issues relating to polypharmacy. We identified instances where medications had directly or inadvertently contributed to the presenting event, indicating that a medication review may have prevented the ED event.

> …she went to hospital … because she was maybe falling off the chairs … they took her off all the medications and reintroduced one by one … they told me that the opioid patch will possibly cause her to have a fall … they did not think it was necessary. (Family member; hearing transcript)

> …"Why is he on Phenergan with Madopar? These things are incompatible. and that was the moment at which he was taken off that drug, but after he'd broken his hip, it was too late. (Family member; hearing transcript)

In other instances, examination of residents revealed situations that were indicative of poor-quality care, including inadequate continence care and poorly treated pressure injuries. Sometimes these conditions led to the ED transfer, while at other times they were discovered by ED staff during the medical assessment.

> … the furrowed brows and low tones illustrated the gravity of the concern. The incontinence aid was removed … I stood for a moment gaping at the item which had clearly been in use for an unacceptably extended period of time; an item that … breached all levels of basic hygiene and human standards. I believe that Mum's fall was directly attributable to the state of her incontinency care as she was trying to mobilise due to discomfort. (Family member; hearing transcript)

> While at the hospital with my Dad, one of my sisters was told that Dad had untreated or very poorly treated pressure sores on his heels … When I visited dad at the facility, Dad was usually covered by a sheet or blanket… the matter had not been brought to our attention prior to Dad's hospital admission for his broken leg. (Family member; hearing transcript)

Here, we identified ED transfer events that reveal previously hidden or downplayed substandard care. Family members reported being shocked and saddened when ED staff revealed the consequences of poor-quality care in the RACF. Without an ED transfer, there is no knowing how long the conditions of poor care would have continued for, or the long-term consequences of such neglect.

DISCUSSION

This study conducted an analysis of the evidence (data) collected during an Australian RC. In doing so, we have not attempted to replicate or question the approach of a royal commission; instead, we identified new insights about ED transfers from RACFs using a scholarly qualitative approach. Our themes have presented evidence that aligns with some of the foremost concerns around avoidable transfer and more nuanced evidence that received less attention in the literature and the Royal Commission reports. With the current focus on addressing the shortcomings in Australia's residential aged care sector, our results highlighted additional gaps in research and practice.

The three themes identified through our analysis; shortfalls and failings, hesitancy and misunderstanding, and discovery and exposure, are fundamentally connected to ongoing workforce issues and healthcare access that have been documented extensively in the literature.[2 8 24] At present, transferring a resident to hospital may be making the best of a bad situation, in many cases alternative clinical and acute care is simply unavailable. It is unlikely we can write anything here that materially adds to what the RC and other stakeholders have reported about the inadequacy of the Australian RACF workforce. Instead, we focus our discussion on the additional insights gained from our analysis. In line with our critical realist approach, we make recommendations of a practical and deconstructionist nature

From the RC data as well as other literature, the idea that hospital level care is not always needed or indeed useful, is well established. There have been Australian interventions where providing higher levels of primary care have resulted in fewer transfers to ED.[25] However, other studies have failed to detect a significant impact on transfer reduction[26] indicating the potential complexity of factors involved. The problems identified around transfer communication between RACF's and hospitals is also embedded in the capacity of the aged care workforce to provide timely and comprehensive resident information, as well as a lack of an electronic medical record system across health and aged care settings. Our thematic findings also highlighted the apparent lack of attention paid to ACDs. Considering there are already inadequacies with information transfer and integrated care, an ACD provides important personal and clinical information, especially for residents with cognitive impairment.[27] While there is some evidence that ACDs do not influence ED decisions, where residents do transfer with an ACD, their length of stay is shorter and readmission rate lower.[28]

Our nuanced thematic findings have identified specific areas of concern, many of which can be acted on without the need for structural industry reform. We have shown that staff are at times hesitant to make decisions because they are unsure or unable to make clinical assessments. It should be noted that the complexity of decision making is different in RACFs compared with work in an acute hospital setting. Multiple considerations in making the decision to transfer or not, are often the responsibility of a single registered nurse in relative isolation, illustrating the need for specialism

in aged care nursing (and not just more numbers of registered nurses). Without this specialist skillset residents will suffer needlessly in both RAC and ED, families will intervene to make non-clinical and fear-based ED transfer decisions, and EDs will be overburdened as the care institution of last resort. In instances where residents do not have family support or advocacy, their needs may remain unmet.

Inadequate clinical assessments are particularly detrimental to residents with restricted language or cognitive ability, or conditions that obscure pain expression.[29] Aged care residents with limited language capacity are especially reliant on the skill and observations of care workers to ensure comfortable and appropriate care. While there are effective options and strategies for cross cultural clinical assessment,[30] as we have reported, such tools are not always employed. This situation may speak to workforce capacity or to cultural assumptions around pain experience.[31] In the instances we presented, dismissing pain appeared a function of negative attitudes or inexperience. Whatever the case, the evidence surrounding inaction indicates a specific deficit of care that was not recognised by the RC. Understanding pain expression is especially vital for residents with cognitive impairment, such as dementia,[32] or other verbal limitations, such as limited English proficiency.[33] Healthcare workers have a moral and ethical responsibility to provide pain management,[34] and aged care workers are not exempt from this obligation.

Apart from workforce issues, the need for timely, relevant and informed communication between health and aged care providers, and families, which prioritises resident needs and preferences, is central to improved decisions about ED transfers. When transfer to hospital must happen, appropriate handover and transfer of information is needed. An electronic health record (EHR) that is accessible across sectors is core to finding an effective and sustainable solution,[35] and it too requires dedicated government funding to realise. Key elements of this EHR should include diagnoses and medications, as well as person-centred information about the older person that includes their advance care plan and strategies that RACF staff know eases their distress, especially when this is exacerbated by acute delirium and/or coexistent dementia.

Improving the RAC workforce involves more than increasing the number and mix of clinical staff. We must also attend to the ubiquitous problem of ageism and the poor esteem society in general holds for older people.[21 36] While research targeting aged care workers is scarce, reports have shown that within healthcare generally, nurses attitudes towards older people are becoming less positive.[37] Finding ways to assess and reduce negative attitudes towards older people will be important for providing high-quality care and for attracting and retaining high -quality staff within the sector.[38 39] Attitude change research is a matter not identified by the RC and is an avenue of study that does not need to wait for structural industry change before implementation.

Strengths and limitations

The Australian Royal Commission into Aged Care Quality and Safety was established to investigate allegations of substandard care and abuse. Accordingly, the submissions have provided accounts of poor care and negative experiences. There are very few accounts of satisfaction with care or praise for aged care workers and providers. This tone is emphasised by the legalistic framework common to all Royal Commissions. Our analysis aimed to take the accounts provided and analyse them from a critical realist perspective, using experience to inform practice and to identify further recommendations. A strength of the approach we have taken is in the management and curation of a large corpus of qualitative data and the rigorous, repeatable methods used to access topic-specific content to facilitate analysis.

One of the restrictions of conducting secondary data analysis is the inability to ask follow-up questions of contributors to clarify and probe further. However, this is somewhat countered by having access to an unprecedented collection of evidence produced by the Australian public when they were offered the opportunity to say whatever they wanted to say on quality and safety in aged care, without the constraints even of a qualitative researcher focusing the topic first. Despite the uniqueness and volume of the data, there were noted restrictions in the voices present; our evidence lacks the voice of the older person and of the workforce. While giving equal attention to all voices in the data, we were limited to the voices present. The lack of extracts from older people and the workforce (including registered nurses) is not a deliberate omission, these voices were not forthcoming within this topic. In addition, when extracting the topic specific data set we noticed that coverage of an ED transfer event was often tangential to a larger conversation around care provision and at times potentially valuable contextual data were not available.

CONCLUSION

It is clear from the evidence presented that the delivery of clinical care must be brought up to expected standards if the goals of reducing unnecessary transfers is to be reached and the care of people in RACFs can be achieved. Further work is needed to understand the barriers and enablers to delivering quality clinical care in RACFs, especially the interplay between organisational characteristics (eg, ownership type, size and location), staff characteristics (eg, skills, confidence, decision-making authority and attitudes), resident casemix (eg, funding type, clinical profile and complexity), their preferences (eg, hospitalisation and end of life care) and family involvement. While there is no doubt that large scale industry change is required, we also suggest areas of targeted research which can be achieved without delay. Research mapping the attitudes of care workers towards older people to determine if and where interventions addressing ageism are needed would potentially improve the experience of care for

many older people. Cultural competency training, especially within the domain of pain expression and response also would be valuable in providing higher level care without high level structural and systemic change. While none of these solutions are simple, more specialist nurses and appropriately trained healthcare workers along with targeted testing and translation of interventions across all parts and levels of the aged care system will contribute to improved outcomes for older people receiving aged care services.

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Competing interests None declared.

Patient and public involvement Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

Patient consent for publication Not applicable.

Ethics approval Although this study uses publicly available data and as such does not involve consenting human participants, due to the sensitive nature of the data, Ethics approval was sought. This study was approved by Edith Cowan University Human Research Ethics Committee (HREC 2019-01007). Participants gave informed consent to participate in the study before taking part.

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