Consumer-centred Care - Seamless Service Needed

This issue, Health and Disability Commissioner Anthony Hill discusses a recent case that highlights what can be required to deliver a seamless, consumer-centred service for a patient with both aged care and mental health needs.

Patients will often move from one part of the health care system to another, and back again, as they access the various services they need. It is common for patients to have more than one issue or diagnosis. For example, a patient with an intellectual disability may also suffer from mental illness, or an elderly patient may have co-morbidities which are not related specifically to age.

In order for patients with complex needs to receive appropriate services there must be a series of systems, including skilled people, all working together to deliver a seamless service to that patient. Where any one or more of these safeguards does not operate optimally there is the potential for delivery of appropriate services to be compromised.

The importance of ensuring a seamless consumer-centred service for a patient with complex needs was highlighted for me in a recent case I considered.

Older patient needing acute mental health care

In case 09HDC01408, 17 June 2011, (available at www.hdc.org.nz) a 64-year-old man was admitted to a mental health acute care unit under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA). The man had been previously fit and healthy and had no history of mental illness, but at the time of admission he was floridly psychotic and considered a risk to himself and others. He was suffering hallucinations and his conversation was bizarre with a strong religious orientation. Various possible diagnoses of his condition were discussed and considered such as frontal lobe dementia, Lewy body dementia, some form of psychosis or a brain tumour. Over the initial months of his admission various medications were trialled to control his delusions. Initially, oral medications were used (olanzapine, epilim, risperidone and haloperidol). Each drug was given a trial of about a month by which time, if he had been compliant, he would have been expected to show some response. The man's family were of the view that he was failing to take the medication, although he denied this.

After a period of time the man became less co-operative, refusing to take oral medication, change his clothing, wash his clothing or shower. The staff of the acute care unit considered that their failure to intervene and attend to the man's personal cares was not due to a lack of care or neglect but because they considered intruding would be an invasion of the man's privacy and seen as bullying. The view was to encourage the patient's autonomy rather than impose cares on an unwilling patient.

It was decided that as the man was refusing all oral medication he should receive his medication by injection and he was, after ongoing refusals, prescribed the drug fluphenazine decanoate by injection. The Medsafe datasheet recommended that the medication should be used with care in people over the age of 60 and that doses amounting to a quarter or a third of the doses used in younger adults should be sufficient. The datasheet stated that if an increase was necessary the doses should be gradually increased. The doses for younger patients was 12.5 – 25 mg to initiate the therapy. The man was given one initial test dose of 12.5 mg, and the amount given amounted to at least 162.5 mg given between 21 April and 28 May.

After an initial improvement the man suffered what his family refer to as "his crash". His movements suddenly became more wooden, his speech was delayed and his facial expressions became blank. He was never again able to recognise his family. His mental state deteriorated further and his ability to provide his own cares reduced. His family complained that he was neglected and dirty.

"Start slow and go slow"
The HDC expert geriatrician adviser, stated that "A more cautious approach (… the geriatric adage: "start slow and go slow") may have prevented this serious outcome, although even low doses can cause problems in a person who is sensitive."

Autonomy and strategies for dealing with unco-operative patients
The man's family believed that by leaving their father dirty and unkempt he was not treated with respect. However, the hospital defended the actions of the staff saying that when the man was unco-operative or aggressive it would have been unsafe to try to shower him under restraint. The acting unit manager told the family that they left the man dirty and unkempt because it would upset him if they attempted to intervene and if they took his clothes at night while he was sleeping and laundered them, this would invade his privacy. The family say he was a sound sleeper and his laundry could easily have been handled while he was sleeping.

Although staff in acute psychiatric units are focused on encouraging independence and avoiding being intrusive or directive, the man required the strategies commonly used by dementia unit staff to provide cares for irritable or unco-operative patients. As I said in my opinion on the case:

> I accept that Mr A would not have been easy to care for but it is not uncommon in mental health or dementia units for there to be issues with hygiene and/or personal care. Organisations must have strategies for dealing with this. It is important to care for physical as well as mental health needs.

I also noted that this office, in a previous opinion (05HDC09043, March 2006), found a DHB had breached Right 4(1) of the Code where the clinical staff did not have a clearly defined or structured management plan for a patient recognised by the clinical staff to be challenging. Knowing the patient was "at the difficult end of a really difficult spectrum", it was even more important to have such a plan.

Similarly, in another opinion about rest home care (08HDC17105 August 2009), the Deputy Commissioner highlighted the responsibility of staff to explore different strategies and work with families to manage difficult behaviour and poor personal hygiene in dementia patients.

Communication key to seamless care
Returning to the case I summarised earlier in this article, the organisation has since taken positive action to improve the pathway of care for patients who at different times require both hospital care and psychiatric care. The process that has been established is that nursing staff from the elder care unit come to the psychiatric unit to assist and provide advice regarding physical care for elderly patients, and monitoring of changes in the patient's behavioural presentation in conjunction with the psychiatric unit staff. When the patient is transferred back to the elder care unit nursing staff from the psychiatric unit remain in the elder care unit until the staff there feel able to manage without their assistance.

This case demonstrates the importance of recognising that what is required to treat an older patient may differ from the usual treatment of a psychiatrically unwell younger patient, both with regard to the quantity of medication administered and also with regard to the personal cares that are required. Each service had skills and knowledge to benefit the patient and these needed to combine effectively to meet the holistic needs of a complex patient. It is essential that different units within the same system communicate well and ensure that there is a safe and seamless system to ensure that the patient moves between the different providers and receives appropriate care at all stages.

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NZ Doctor, 24 August 2011