

## Elsie's Story

**Elsie has a hard time remembering things, but every time that Elsie sees a clinician, she's expected to retell all the details of her medical history. Her family find it difficult to get information.**

### Can we do better?

What systems can we set up so that:

- Adequate information is provided to consumers after time in hospital?
- Clinicians can easily contact each other to share information?
- Shared assessment templates are made available to all care providers?
- Collaboration and coordination of care are improved?
- Family are informed about assessments?

Elsie, eighty-seven, was living independently in a unit complex attached to an aged-care facility.

Apart from some domestic assistance every two weeks, she was completely self-sufficient. She was socially connected to her local community and still driving her own car, but suffered from heart disease, short-term memory loss and severe osteoporosis. Because of the osteoporosis, she needed a total hip replacement.

After the operation, her cognitive impairment became more apparent, and she struggled with any instructions or new information. While still in the hospital—and with no family present—she was assessed for on-going home care. When her daughter visited, Elsie asked her to interpret the information left behind by the service provider. To Elsie, the three brochures the service provider had left were “meaningless” and “double Dutch”. Elsie described her hospital stay as like “being in another world”.

In the hospital, Elsie was taken off the heart medication (the white pill—as she described it) that she'd been taking for the last thirty years. She was told to see her GP about this. Her family arranged for Elsie to see her GP one week after discharge, but the practice had not received any information about her hospital stay, the medication changes or the care plan.

Unfortunately, this lack of communication continued. Over the next eight months, Elsie had twelve more interactions with health sector organisations, each one requiring a new assessment, with Elsie or her family having to repeat the same story over and over. When the family were not present, Elsie's declining cognitive function meant that the details she provided were often fragmented, with important snippets of information forgotten.

It was only toward the end of this period that health providers began to actively review previous assessments and consult with each other.

Elsie's family included medical professionals who were ready to support and advocate for her. But even though they had an understanding of the health system and the services available, they were not able to prevent Elsie's repeated assessments, being told that these were procedural requirements of the organisations.

All of the clinicians involved in Elsie's care had good intentions and supported her where they could, but all were bound within their organisational processes. In one incident, for example, Elsie had a fall while out in the community. The paramedics who attended were very supportive in picking her up and assessing her condition. They patched up some broken skin and drove her home when she said she did not want to go to hospital.

However, there were no established systems in place for them to alert other services or family members, and not having a full history, they were unaware of Elsie's declining cognitive functioning. Elsie's family only found out about the incident when they later discovered her unconscious on the floor, and took her to the hospital emergency department. Elsie was eventually admitted to an aged-care facility, where she resides today.