

Ruby's journey

Richmond LGA – Multipurpose Health Service – Renal Failure and Cardiovascular Disease

Ruby is an 82 year old widowed woman who resides in an aged care bed at the Richmond Multipurpose Health Service (MPHS). Ruby has renal failure and cardiovascular disease secondary to type 1 diabetes. The doctor and nursing staff have noticed a severe decline in Ruby's wellbeing over the last 6 months - a reduced appetite, sleeping a lot and reduced mobility.



VISITING SERVICES

Ruby sees the visiting diabetes educator and allied health services from Townsville once a month.

RUBY MOVES INTO RICHMOND MPHS

Ruby's mobility doesn't improve. She refuses to move to an aged care facility in Brisbane near her daughter. The nurses support Ruby & her daughter through their difference of opinion. Ruby's daughter is very distressed when she must return to Brisbane.

HOME CARE PACKAGE

Richmond Aged Care (RAC) workers are a constant presence in Ruby's life for many years. The RAC workers know Ruby wants to stay at home and doesn't want to move. They notice a blank Statement of Choices form on Ruby's bench but she refuses to talk about it.



RUBY HAS A FALL

RAC calls 000. Hospital-based ambulance responds. It takes Ruby's only daughter 2 flights and 48hrs to arrive from Brisbane.

SPECIALIST PALLIATIVE CARE

Nurse recommends the Medical Superintendent refer Ruby to Specialist Palliative Care Rural Telehealth (SpaRTa) to assist with pain management, nausea and advance care planning.

ONGOING NURSING CARE

Richmond MPHS nurses provide ongoing care and receive support from SpaRTa as required via telehealth. Ruby's ageing friends visit occasionally.



RUBY'S CONDITION DETERIORATES

Nurse calls Ruby's daughter. SpaRTa recommend a syringe driver. The recommended medications are not available in Richmond. It takes 48hrs for the medications and Ruby's family to arrive.

BEREAVEMENT

Ruby dies 1 day after her daughter & grandchildren arrive. The MPHS nurses support the family. The SpaRTa social worker assists the family with referral for ongoing bereavement support.

Key Themes:

- Remote location - 500km to Townsville
- No direct flights to Brisbane
- One doctor is the GP & Hospital Medical Superintendent
- Pathology only available 4 days a week (point of care 24/7)
- Advance care planning - moving away vs staying
- Visiting service availability
- Only 4 funded aged care beds at MPHS
- Long standing relationship with Aged Care workers

Potential issues/barriers:

- Timely access to medication, pathology & medical aids
- Ability to make early referral to SpaRTa - patient/family consent and early recognition of end stage disease
- SpaRTa input in time to plan for end of life care before imminent death
- Aged care bed availability
- Telehealth coordination
- Completing demands on generalist workforce (ambulance & acute vs aged care)



An initiative of
PalliativeCare
QUEENSLAND
PALLIATIVECAREQLD.ORG.AU

Supported by



The CELC Townsville project is administered by Palliative Care Queensland and supported by funding from Northern Queensland Primary Health Network (NQPHN) through the Australian Government's PHN program.