Management of Patients Awaiting Aged Care Services Procedure

1. Purpose

In accordance with the WA Health Patients Awaiting Aged Care Services Including Transition Care Program Policy – MP 0173/22, admitted older patients waiting for aged care services require early identification and management to facilitate a timely and safe discharge. Older patients are defined as 65 years and over for non-Aboriginal and 50 years and over for Aboriginal. Note: For existing or potential National Disability Insurance Scheme (NDIS) patients follow the NDIS pathway (WACHS NDIS Resources, Training and Education).

The following principles[1] apply for patients who are waiting for aged care services (either residential or community-based) whilst in hospital:

- patients will be treated with dignity and respect
- patients will be encouraged and supported to participate in decision making about their ongoing care
- patients will be provided with information in a format they understand so they can participate in decision making (including the use of an interpreter if required)
- carers/family members/patient representatives should be involved in decision making where appropriate
- coordination of care and multidisciplinary teamwork is essential so that patients receive the best possible care in a setting that best meets their needs
- care is individualised and reflects the patient's needs, values and preferences.

2. Procedure

2.1 Identification of Patients Awaiting Aged Care Services (PAACS)

- On admission patients should be identified as potentially requiring aged care services on discharge. The multi-disciplinary team must undertake assessment of the key indicators at all stages of the patient's episode of care. The key indicator questions (see Appendix 1) assist in assessing safe discharge options for the patient. When the treating Doctor has deemed the patient is medically ready for discharge the following options should be considered (see Appendix 1):
  - The patient has previously had an Aged Care Assessment Team (ACAT) assessment and been approved for aged care services.
  - These services are deemed to currently meet the patients support needs.
  - If the patients support needs have changed significantly, determine if the existing Home Care Package (HCP) is being fully utilised or if a new referral to ACAT should be considered.
  - The patient returns home with usual supports and/or family. A referral for a community ACAT assessment can be made for services such as a HCP if necessary.
  - The patient requires a Residential Aged Care Facility (RACF) or the Transition Care Program (TCP). A referral should be made to ACAT for an assessment whilst they are in hospital.

- A staff member must be assigned as the patient's key contact person. They are responsible for liaising with the hospital team and the patient (or an identified representative).

2.2 The Key Contact

The Key Contact is a member of the multidisciplinary team who is a central figure in the PAACS Transition process. They are identified on admission if the likely discharge will be to a RACF.

The Key Contact person completes the following tasks:

- introduces their role to patient/representative during initial discussions about discharge options including RACF
- provides the Patients Waiting for Aged Care Services brochure, Australian Healthcare Rights and supports access to the MyAgedCare website and provides the patient/representative with Your Guide to Home Care Package Services or Steps to Enter an Aged Care Home
- Explains to the patient/representative the potential for charges once the patient has been deemed medically fit for discharge.
- offers an interpreter service if English is not their preferred language or there are other perceived language barriers
- offers to connect the patient with culturally appropriate support, such as the Aboriginal Liaison Officer
- identifies if the patient wishes to have a primary point of contact (representative), or if the patient has an Enduring Power of Guardianship, and if a substitute decision maker has been appointed by the State Administrative Tribunal
- collates all relevant clinical and social information from the multidisciplinary team and patient/representative to support discharge planning
- facilitates family meetings as required with the treating team to discuss patients' care needs, concerns and actions identified to facilitate discharge
- explains the potential risks of remaining in hospital to the patient and their representative (e.g. hospital acquired complications such as infections)
- completes the MR66.10.2 WACHS Awaiting Aged Care Services Transition Plan in consultation with the patient/representative.

The key contact advises the patient and their representative:

- of the requirement to waitlist at a minimum of three RACF within a reasonable geographical area
- that regions with less than three RACF, will require consideration of all available RACF options within a reasonable geographical area
- that patients should accept the first vacancy available at a RACF while they wait for their preferred option
- if they do not accept the first available place, they will be transferred to an RACF/Multi-Purpose Services (MPS) Site or access suitable supports for discharge home

The key contact:

- confirms wait listing with the preferred services and/or facilities, provides a detailed referral and handover to the site as needed, identifies any complex discharge triggers and monitors progress for vacancies at the preferred RACF

- links the patient/representative with the Department of Human Services or the Department of Veterans' affairs where required to assist with the RACF applications and the income and assets assessment.

2.3 Discharge Planning

- A referral must be made to appropriate services for further management and consideration of ongoing care needs if required. This referral can occur in parallel with other acute services. (Completion of the Blaylock Tool on the MR111 WACHS Nursing Admission, Screening and Assessment Tool - Adults will inform the treating team as to the status of the patient).
- This must include consideration of potential for improvement and continued prevention of functional decline prior to a definitive plan to discharge to an RACF.
- Referral for an ACAT assessment if existing approvals for Commonwealth Aged Care Services are not already in place. (Any delays in accessing the ACAT assessment should be escalated to the Regional Aged Care Manager).
- If the patient is to be discharged with a HCP, refer to ACAT and the assessment must be completed in the patient's home to reduce impact of staying in hospital. Emergency Commonwealth Home Support Programme (CHSP) or private services can commence until a HCP becomes available. (This should only be considered where the patient has carer or family support available).

The discharge management plan must:

- detail an estimated date of discharge to a RACF or home with services, including outlining the respective roles of the aged care provider and the hospital team
- outline the responsibilities of all parties towards obtaining a suitable RACF
- include completion of the MR66.10.1 WACHS Non-Acute Resource Utilisation Group - Activities of Daily Living (RUG-ADL) Assessment within 24 hours of care type change and upload into the webPAS Subacute Module
- advise that non-acute patients are charged a daily fee after 35 consecutive days in hospital (*Health Insurance Act 1973* and *Private Health Insurance Act 2007*).
    - provide this advice in writing and verbally, by the health service provider to the patient and their representative, that the patient is to be charged the daily care fee for accommodation and nursing care while waiting in hospital
    - the 35-day continuous period may accrue in a single or in two or more hospitals. Transferring between hospitals has no effect on the qualifying period
    - Note: Patients who meet the continuous period and remain in hospital for ongoing acute care will require an acute care certificate from the treating medical officer (WA Health Patient Fees and Charges Manual 2022/23)
- ensure discussion with the patient or family members/patient representatives regarding aged care services and RACF options in parallel to rehabilitation to prepare the patient for future transition to a RACF if required
- identify if the patient has a cognitive impairment or impaired decision-making diagnosis, so an application can be made to the State Administrative Tribunal (SAT) for Guardianship and/or Administration Orders. The SAT application must be completed and lodged as soon as it is identified that the patient requires a substitute decision maker to minimise any delays in discharge. (WACHS Adults with Impaired Decision Making Capacity Procedure)
- identify the agreed discharge destination and the key contact person must liaise with the facility/services regarding the transfer of care.

2.4 Escalation Planning

Early Indicators of discharge delay

If any of the following situations arise that are likely to result in delayed hospital discharge, then escalation must be initiated to the Nurse Manager in the first instance. Further escalation to the Operations Manager (or localised equivalent) may be required for complex discharge planning.

- No family or unable to contact family/family not available.
- Family not attending scheduled meetings or unresponsive to correspondence.
- Family conflict
- Frequent changes to discharge plan, either by family, hospital or chosen RACF.
- Refusal to outlie
- Lack of flexibility by family concerning which facility the patient may be discharged to.
- Lack of suitable options for patient due to complex care needs, including behaviours of concern or cultural needs (e.g. Significance of remaining 'on country' for Aboriginal people or prior experiences of institutional care).
- Approaching the estimated date of discharge with no agreed discharge plan in place.
- Patient representative not able to reach a decision/agreement that is in the patient's best interests.
- Non Australian resident
- Complex financial issues (e.g. Hardship).
- Delay in accessing guardianship services through the Office of the Public Advocate or waiting for State Administrative Tribunal hearings.

Escalation Plan

The following escalation strategies relate to the patient and or their representative has declined to accept the first vacancy available. The escalation strategies can also be adapted in the case of other barriers that are precluding discharge of a patient.

- The key contact person must arrange another family meeting to support the patient and their representative to engage with the discharge planning process. Attendees must include the patient (where appropriate), family/carer/guardian, medical and multidisciplinary team, Nurse Manager and Operations Manager or Hospital Director (as appropriate). The meeting must:
  - allow the patient and/or their representative or advocate the opportunity to explain their perceived barriers/concerns regarding discharge
  - ensure the patient and their representative understands that discharge to a RACF/MPS site is suitable for their needs and that a prolonged stay at an acute hospital is associated with adverse outcomes for older people
  - review alternative discharge options including discharge into the care of the family and additional reasonable RACF waitlisting
  - ensure that the key contact person informs the family of the requirement to visit available RACF within an agreed timeframe (e.g. 24 hours) of being notified of a vacancy to support discharge planning
- If no follow up has occurred within the agreed timeframe or if there remains a dispute or disagreement, the key contact person is to advise the Operations Manager or Hospital Director. The Operations Manager/Hospital Director should contact the patient and/or their representative to resolve the situation. If a resolution is not reached, then the Regional Director should be informed. If after 35 days acute medical care is no longer

required, the patient will be charged a daily fee. For patients classified as a Nursing Home Type Patient, local processes will be applied (refer to the WA Health Fees and Charges Manual).
- Health Service management (Operations Manager/Hospital Director and/or Regional Director) are able to make a decision regarding the need for beds and transferring the patient to another health service site if appropriate and no agreement is obtained.
- The key contact person must summarise any concerns raised, information provided, agreed actions and persons responsible for these actions in the patient's health record.

3. Roles and Responsibilities

Regional Directors are responsible for the following governance and compliance processes:
- assigning roles and responsibilities necessary to enact and manage compliance with the WA Health Patient Activity Data – MP 0164/21
- ensuring activity data is compliant with this procedure prior to submission to the Aged Care Directorate
- responding to any discharge delay issues raised by the operations manager and addressing concerns of the patient and their representative.

Operations Manager/Hospital Director is responsible for:
- resolving discharge delays in consultation with other key staff, and addressing concerns of the patient and their representative
- ensuring education and direction to staff members is facilitated in the application of this procedure
- establishing monitoring and audit processes to measure compliance
- decision making regarding the need for beds and transferring the patient to another health service site if no agreement is obtained.

Area Director Aged Care is responsible for:
- ensuring implementation WACHS wide of the policy and monitoring compliance through receipt of quarterly PAACS data
- evaluation, monitoring of data for WACHS Quarterly Performance Meetings.

Regional Aged Care Managers are responsible for:
- acting as a single point of contact for the region for the dissemination of information regarding patients awaiting aged care services (PAACS)
- coordinating the reporting of PAACS data.

Directors of Nursing and Health Service Managers (including Nurse Managers) are responsible for:
- ensuring implementation of the policy across the region and monitoring compliance
- assisting in resolving discharge delays in consultation with other key staff and addressing concerns of the patient and their representative.

All staff are required to work within policies and guidelines to make sure that WACHS is a safe, equitable and positive place to be. **All staff** are responsible for appropriate discharge and care planning and completing forms and documents in line with processes and standards.

4. Monitoring and Evaluation

4.1 Monitoring

The WACHS Aged Care Directorate requires each hospital to record the number of patients awaiting aged care services daily. Monitoring will include:

- length of stay in an acute hospital for those requiring placement
- completed management plans identifying potential for RACF placement
- patient and representative satisfaction/complaints.

4.2 Evaluation

A report will be made available on a quarterly basis. This information is to be utilised and monitored in Quarterly Regional Performance Reporting.

5. Compliance

Failure to comply with this procedure may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Integrity Policy Framework issued pursuant to Section 26 of the *Health Services Act 2016* and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies and procedures is mandatory.

6. References

1. Australian Commission on Safety and Quality in Healthcare - Principles of Care
2. Homecare Package Calculation of your cost of care form (SA456)
3. My Aged Care – Consumer and Service Provider web portal
4. Victoria Government Minimising the risks of transitions
5. Victoria Government Providing best care for older people
6. The Australian Charter of Healthcare Rights (second edition) - A4 Accessible

7. Definitions

Term	Definition
Aged Care Assessment Team (ACAT)	ACATs conduct a comprehensive assessment of the restorative, physical, medical, psychological, cultural and social dimensions of a person's care needs as and when appropriate.
Aged Care Services	Aged Care Services is the umbrella term for the following Commonwealth funded programs: • Permanent Residential Aged Care • Home Care Packages (HCP) Levels 1 – 4 • Flexible Care - Transition Care Program (TCP) • Residential respite.

Acute Care	Treatment for patients with high level medical care associated with a short term or episodic illness, injury, or recovering from surgery.
Commonwealth Home Support Program (CHSP)	The Commonwealth Home Support Programme (CHSP) helps older Australians access entry-level support services to live independently and safely at home.
Carer	A carer is a person who provides ongoing care, support and assistance to a person with disability, a chronic illness or who is frail, without receiving a salary for the care they provide (WA Carers Recognition Act 2004).
NDIS	National Disability Insurance Scheme supports people with a permanent and significant disability that affects their ability to take part in everyday activities. Detailed information is available from National Disability Insurance Scheme | Department of Social Services, Australian Government (dss.gov.au)
Home Care Package (HCP) Consumer Directed Care	A HCP is a coordinated package of services tailored to meet a person's specific care needs. Consumer directed care provides the consumer with added flexibility and choice in the delivery of care and services under the home care package. Detailed information is available from Home Care Packages | My Aged Care
Multi-Purpose Service site	The Multi-Purpose Services (MPS) Program provides integrated flexible health and aged care services to regional and remote communities in areas that can't support both a separate aged care home and hospital.
Residential Aged Care Facility	Residential Aged Care Facility is for older people who can no longer live at home and need ongoing help with everyday tasks or health care
Residential Aged Care	Residential Aged Care is care that is provided to a person in a residential facility in which the person resides.
Reasonable	Reasonable refers to the distance that is suitable for the older person and/or significant other/s to ensure continued face to face contact and or culturally appropriate connection with country.

8. Document Summary

Coverage	WACHS-Wide
Audience	Medical, nursing, allied health and executive managers
Records Management	Records Management Policy Health Record Management Policy
Related Legislation	*Aged Care Act 1997* (Commonwealth) *Quality of Care Principles 2014* (Commonwealth) *Health Services Act 2016* (WA) *Mental Health Act 2014* (WA) *Health and Disability Services (Complaints) Act 1995* (WA) *Health Insurance Act 1973* (Commonwealth) *Disability Services Act 1993* (WA) *Carers Recognition Act 2004 (WA)*
Related Mandatory Policies / Frameworks	MP 0164/21 Patient Activity Data MP 0173/22 Patients Awaiting Aged Care Services Including Transition Care Program Policy Clinical Services Planning and Programs Policy Framework Information Management Policy Framework
Related WACHS Policy Documents	Admission, Discharge and Intra-Hospital Transfer Clinical Practice Standard Adults with Impaired Decision Making Capacity Procedure
Other Related Documents	WA Health Fees and Charges Manual 2022/23
Related Forms	MR111 WACHS Nursing Admission, Screening & Assessment Tool - Adults MR66.10.1 WACHS Non-Acute Resource Utilisation Group - Activities of Daily Living (RUG-ADL) Assessment MR66.10.2 WACHS Awaiting Aged Care Services Transition Plan
Aboriginal Health Impact Statement Declaration (ISD)	ISD Record ID: 1946
National Safety and Quality Health Service (NSQHS) Standards	1, 2.01, 2.02, 2.03, 2.04, 2.05, 2.06, 2.07, 2.08, 2.09, 2.10, 2.11, 2.13, 5.03, 5.04, 6.01, 6.02, 6.03, 6.04, 6.07, 6.08, 6.09, 6.10, 6.11.

9. Document Control

Version	Published date	Current from	Summary of changes
3.00	16 May 2023	16 May 2023	• Changed from a Policy to a Procedure • Added summarised discharge options, amended requirements for waitlisting at RACF and RACF Vacancy timeframes • Removed Complex Admissions paragraph and added Discharge Planning • Removed Contacting OPA • Roles and Responsibilities updated

10. Approval

Policy Owner	Chief Operating Officer
Co-approver	Executive Director Nursing & Midwifery Executive Director Clinical Excellence
Contact	Senior Project Officer Aged Care
Business Unit	Health Program – Aged Care
EDRMS #	ED-CO-17-58512

This document can be made available in alternative formats on request.

Appendix 1: PAACS Patient Hospital Journey