Subject: TRANSITION CARE FOR THE OLDER PERSON

1. Introduction

The following guidelines have been developed to provide a standardised foundation for the operation of Transition Care for the **older person** (>65 years) across all hospitals in the metropolitan area. Each hospital has site specific procedures that they follow in regard to Transition Care. The aim of the guideline is to foster consistency in approach whilst enabling site specific procedures to be utilised.

2. Background

The primary aim of Transition Care is to relocate the older person who is waiting in a <u>public</u> hospital bed and who no longer requires acute or subacute care by discharging them into non-hospital care or where possible to the patient's own home. This relocation makes available public hospital beds for other patients who require acute medical/surgical or subacute care. Transition Care/Option is provided in an environment and with a style of care conducive to the aims of optimising the patient's level of independence whilst smoothing the transition to home or to residential care.

In 2007, the Australian Government made a commitment to provide an additional 2000 Transition Care places nationally over the next four years. The new Transition Care Program (TCP) offer WA Health the opportunity to convert Care Awaiting Placement (CAP) beds to Transition Care flexible places, providing funding for therapy and allied health. This model moves from a purely maintenance model (CAP) to an enabling and therapeutic model of care.

All eligible patients and where appropriate, their families/carers are encouraged to accept Transition Care. They also have a right to decline that offer.

3. Accessing Transition Care

From 01 April 2010, all patients in metropolitan hospitals who have been *Aged Care Assessment Team* approved, have a completed *Aged Care Client Record* and ARE medically ready for discharge will be classified under one title, **Aged Care Services**.

Aged Care Services is the umbrella term for the following:

- Permanent residential care: high or low;
- Flexible care: Extended Aged Care at Home, Dementia (EACHD), Extended Aged Care at Home (EACH), **Transition Care** (refer Item 4 below); and
- Community Care: Community Aged Care Package (CACP).

Principles and Minimum Standards

The following principles and minimum standards apply in caring for patients who are eligible for *Aged Care Services*:

- The processes and policies take into account the individual needs of the patient and their carer or family;

- The patient and their carer or family are provided with sufficient information in a form that fosters understanding and awareness of expected stages of care. This includes information on the alternate pathways of residential care planning if returning home is no longer an option, or accessing community support services where the plan is to return to their usual place of residence;

- Patients and their carer or family have unencumbered access to appropriate staff, including social workers, to assist them through the process of arranging appropriate long-term care;

- The patient and their carer or family understand and are able to assert their right to complain and to have their complaints dealt with promptly and impartially;

- A clearly defined Care Pathway is available for use and reference by hospitals staff at all points in the continuum of care. The Care Pathway is the foundation for information delivery to all stakeholders in the care of the patient; and

- Clients with complex co-morbid conditions or <65 years will require approval on a case by case basis by the Department of Health, Aged Care Policy Directorate.

4. Transition Care

Transition Care includes the fully State Government funded program (currently known as CAP) and the joint Australian and State Government funded initiative (currently known as TCP).

Transition Care provides short term flexible care options for the frail older person at the interface of the acute/subacute and residential aged care sectors. *Transition Care* is a goal oriented therapy/treatment-based program that aims to reduce inappropriate extended hospital lengths of stay and reduce premature and inappropriate admission to residential aged care. The service is provided in a residential facility and/or in a patient's home.

Underlying Philosophy

Following an acute care episode, many frail older people require more time and less intense therapy and treatment than is provided in an acute hospital setting to return to a higher level of independence.

Transition Care will deliver temporary care for those older patients waiting for admission to *Aged Care Services*, providing further recovery time in a non-acute setting or in the patient's home which offers the older patient a greater opportunity to optimise their level of independence whilst they and their family and carers make appropriate long term care arrangements.

Access priority

Access priority to *Transition Care*, residential places and/or community places is dependent on availability and at the discretion of the *Transition Care* CENTRAL Coordinator.

First priority - metropolitan *Transition Care* referrals in the following order:

- Inpatients of adult public teaching hospitals (Fremantle Hospital Health Service, Royal Perth Hospital, Sir Charles Gairdner Hospital);

- Inpatients of adult hospitals with public Emergency Department beds (Armadale Health Service, Rockingham General Hospital, Swan District Hospital, Joondalup Health Campus);

- Inpatients of adult hospitals without public Emergency Department beds (Bentley Health Service, Kalamunda Health Campus, Osborne Park Hospital, Shenton Park Campus, Mercy Hospital, other private hospitals).

Hospital Discharge

Admission to all metropolitan Transition Care facilities will be allocated to a central waitlist managed by senior clinical representatives from North Metropolitan Area Health Service (NMAHS) and South Metropolitan Area Health Service (SMAHS).

- Patients are to be waitlisted for all facilities suitable to meet their care needs (eg. secure / non-secure) and be counselled that they will be expected to accept the first allocated vacancy, preference will given to a facility within their metropolitan region

- Consideration for allocation of a facility outside the patients normal metropolitan region will be in consultation with all stakeholders

- Prioritisation and allocation of all patients remains the responsibility of the Central Coordinators

Patient profile: The elderly patient:

- Has a current Aged Care Client Record (Form 3020 [0709]) recommending *Aged Care Services* (Permanent residential care - low or high; Flexible care - EACHD; EACH, Transition Care; and Community care - CACP), as assessed by the Aged Care Assessment Team;

- Assessed/approved for permanent Residential Care is to have the Flexible / Transition Care box ticked;

- Is deemed medically ready for discharge by the treating team;

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- Is occupying a hospital bed;

- Can enter *Transition Care* directly upon discharge from hospital;

- Is suitable for GP management; and

- Family or advocate agrees to transfer to *Transition Care*.

As *Transition Care* is a through-put model of care, consideration is also given to any potential barriers to discharge to a permanent place. The following actions are a guide to what is required prior to the *Transition Care* referral/application being considered for those patients who are on the permanent residential aged care pathway.

a. **Residential Aged Care uncomplicated referral** – where the older person **does not** have any complex issues:

- Confirmation that a *Request for an Assets Assessment* form has been lodged with Centrelink and/or Department of Veterans' Affairs;

- Family or advocate is aware that he/she will be discharged to the first available vacancy for which they are waitlisted; and

- Family or advocate is aware that if no vacancies arise they will be requested by the social worker to choose additional residential facilities.

b. **Residential Aged Care complicated referral** – where the older person **does** have complex issues that are likely to be barriers to discharge from *Transition Care* and consequently increase length of stay:

- Confirmation that residential care planning has commenced and waitlisting for at least **one (1) realistic permanent aged care facility has occured**;

- Family or advocate is aware that he/she will be discharged to the first available vacancy for which they are waitlisted; and

- Family or advocate is aware that if no vacancies arise they will be requested by the social worker to choose additional residential facilities.

For the older person who requires Guardianship and/or Administration orders from the State Administrative Tribunal (SAT), the following action is required prior to the *Transition Care* referral/application being considered:

- The SAT application is completed and lodged.

Note: Based on a SAT application taking on average six (6) to eight (8) weeks, patients awaiting a SAT hearing should not transfer to *Transition Care* until three (3) weeks after the SAT application has been lodged.

The following action is required prior to the ***Transition Care*** referral/application being considered for those patients who are on a direct pathway to home.

c. **Home not requiring permanent residential care referral** – where the older person **does not** have or require an approval for permanent residential aged care:

- ***Transition Care*** referral/application forwarded directly for consideration.

> **Note:** Consideration should be given for the longer term plan for this patient post ***Transition Care***.

d. **Home including approval for permanent residential referral** – where the older person **does** have an approval for permanent residential aged care:

- Confirmation that a *Request for an Assets Assessment* form has been lodged with Centrelink and/or Department of Veterans' Affairs.

Target Time frame: Up to 12 weeks.

Those clients admitted to ***Transition Care***, the joint Australian and State Government funded initiative have a possible **ONE** extension of six (6) weeks available per Transition Care episode with further Aged Care Assessment Team approval.

4.1 Role and Responsibilities

4.1.1 Transferring Hospital

It is the responsibility of the transferring hospital to ensure that:

- The patient is medically stable and deemed appropriate for transfer to a ***Transition Care*** facility;

- The placement process (if applicable) has been planned and the plan is actioned prior to the patients transfer to the ***Transition Care*** facility. This will be coordinated by the hospital Coordinator via the ***Transition Care* CENTRAL Coordinator**;

- A detailed hand-over is supplied to the ***Transition Care*** facility via the ***Transition Care* CENTRAL Coordinator** including the specialist needs of the patient as well as any family issues of concern. This should include outstanding outpatient and medical appointments;

- Nursing assessment has been identified and communicated to the Transition Care facility to address technical nursing skills, experience and competencies that may be needed to care for the person (eg. subcutaneous infusion, medications etc and if applicable, in accordance with Transition Care Program Guidelines, Attachment C, Specified care and services for transition care);

- Any behavioural presentations are accurately defined and communicated such that optimal safety of other patients and staff can be considered and appropriate bed allocation is ensured;

- The patient, their family and/or carer is clearly informed of the time-limited nature of **Transition Care**, of fees and charges and of their rights to compliment and complain about the service;

- The patient, their family and/or carer is informed that they will be asked to sign a formal *Transition Care Recipient Agreement*; and

- Reporting is accurate and maintained weekly.

*4.1.2. Admitting **Transition Care** Facility*

It is the responsibility of the admitting **Transition Care** service provider to ensure that:

- Care recipients admitted to **Transition Care** have a formal *Transition Care Recipient Agreement*;

- The care recipient receives a detailed assessment of needs and a plan of care is documented and actioned;

- The placement process (if applicable) is progressed in a timely and sensitive manner;

- The care recipient, their family and carer is clearly informed of the time-limited nature of the **Transition Care** services, of fees and charges and of their rights to compliment and complain about the service;

- If the care recipient again requires acute care, they will be transferred to an acute care facility in a timely manner; and

- Maintain adequate records of care recipients and ensure that evaluation criteria are recorded and reported weekly.

5. Evaluation and Reporting

Reporting is used to determine the maintenance and potential expansion of the program. It is also used to inform the longer term planning strategies especially towards supporting the increase of residential aged care beds/packages with the Australian Government.

It is expected that each site will evaluate its own **Transition Care** program; however, as part of the program evaluation, the Aged Care Policy Directorate of the Department of Health requires each hospital to report their **Transition Care activity** (ie. all those patients medically ready for discharge to **Transition Care**).

6. Weekly Reporting: Patients Awaiting *Aged Care Services*

The Department of Health requires the following reporting.

1. Weekly Reporting: Patients Awaiting **Aged Care Services**

The purpose of this data is to identify on a weekly basis the number of inpatients in a public hospital bed who are ready for discharge and awaiting **Aged Care Services** (Permanent residential care - low or high; Flexible care - EACHD; EACH, **Transition Care**; and Community care – CACP).

Each site collects and reports on individual patients waiting for **Aged Care Services**, reporting client data as at each Wednesday to the Department of Health, Aged Care Policy Directorate. This provides a snapshot of new and existing patients waiting, the level of care they require and discharge destination. Refer Appendix 1 for reporting instructions and proforma.

This reporting can also provide information about how long a person might wait in a hospital before they are accommodated either in a **Transition Care** facility, permanent residential care and/or at home. Sites are also able to use this information to determine the throughput of patients over time.

Only inpatients that satisfy **both** of the following criteria are to be reported on this list.

- **Aged Care Assessment Team** assessed and approved for **Aged Care Services** (Permanent residential care - low or high; Flexible care - EACHD; EACH, transition care; and Community care – CACP) with current and completed **Aged Care Client Record** (Form 3020[0709]); and

- medically ready for discharge. (This does not include those patients who are currently receiving acute medical or surgical intervention, as these patients are deemed to be acute regardless of whether they have a current Aged Care Assessment Team approval and on the waiting list for **Aged Care services**).

It is important to note:

- Inpatients (and their families) who decline a move to a **Transition Care** facility are still to be included on the weekly list as waiting, if the above criteria have been met; and

- Patients do not require to be classified as "Nursing Home Type Patients (NHTP) to be included on the list. Often patients who are waiting will also be a NHTP.

The data is collated to give a system wide view of the number of patients in metropolitan public hospitals waiting for **Transition Care**.

7. Managing Complaints

Care recipients, their family and carers have the right to complain and to have their complaints dealt with promptly and impartially. All hospitals are required to have a complaint's management process.

Complaints related to a *patient's stay in hospital or to their transfer to* a **Transition Care** facility need to be managed by the transferring hospital.

Complaints regarding **Transition Care**, residential and/or community need to be initially directed to the **Transition Care** service provider. If care recipients cannot resolve their dispute with the service provider then the state complaints bodies should be the first point of call; the Department of Health (Aged Care Policy Directorate) as the **Transition Care** approved provider and/or the Office of Health Review.

Unsatisfied complainants still retain the right to lodge a complaint with the Australian Government Aged Care Investigation Scheme operated by the Department of Health and Ageing.

**PATIENTS AWAITING *AGED CARE SERVICES*
REPORTING PROFORMA**
(**Permanent residential care** - low or high; **Flexible care** - EACHD; EACH, Transition Care;
and **Community care** – CACP).

INSTRUCTIONS FOR SITE COORDINATORS

This proforma is to be used across all metropolitan public health services/hospitals to record the weekly number of inpatients in a public health service/hospital bed who are ready for discharge and are awaiting ***Aged Care Services*** (**Permanent residential care** - low or high; **Flexible care** - EACHD; EACH, Transition Care; and **Community care** – CACP)..

WHO SHOULD BE INCLUDED ON THE LIST?
Only inpatients that satisfy ***all*** the criteria numbered below should be reported on this list. These patients are defined for reporting purposes as "*Ready for Discharge*" as per the proforma.

Ready for discharge inpatients are those who are:
1. Aged Care Assessment Team (ACAT) assessed and approved for ***Aged Care Services*** and have a current and completed Aged Care Client Record (ACCR Form 3020 [0709]); and
2. Medically ready for discharge. This does not include those patients who are currently receiving acute medical or surgical interventions, as these patients are deemed to be acute regardless of whether they have a current ACAT approval and are on the waiting list for ***Aged Care Services***

Please also note the following:
- The data should include all people waiting for ***Aged Care Services*** and not just those waitlisted to enter a ***Transition Care*** facility;
- Inpatients (and their families) who do not accept a move to a ***Transition Care*** facility are still to be included on the weekly list as waiting, if the above criteria have been met; and
- Patients do not require to be classified as "Nursing Home Type Patients" (NHTP) to be included on the list. Often patients who are waiting will also be NHTPs.

The "*No of days awaiting permanent **Aged Care Services***" is the number of days since the patient was deemed "Ready for Discharge", as per the above definition.

REPORTING
- Sites are to report data as at every Wednesday to the Department of Health (Aged Care Policy Directorate;
- If patients are discharged please complete the discharge date and discharge location. Please specify if the patient has been discharged to a ***Transition Care*** facility;
- If the patient is deceased, the date of death is recorded in the discharge date column and destination is recorded as "deceased";
- Patients who were "ready for discharge" and were discharged within the week, but outside the reporting snapshot (i.e. Thurs-Tues) should also be included in the first Wed following their discharge;
- Please remember to change "today's date" as this required for the formulas in the proforma to work; and
- Please forward your weekly data to ***Transition Care Data***

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*   Health Service beds include acute, non-acute and psychogeriatric beds