Management of Patients Awaiting Aged Care Services Policy

1. Background

This policy will guide the early identification and management of patients (65 years and older and 50 years and over for Aboriginal and Torres Strait Islander patients) who have been admitted to hospital and are considered unlikely to be able to leave hospital without additional support provided by a package of care or who require discharge to a residential aged care facility (RACF).

2. Policy Statement

This policy aims to ensure that consistent processes and information are used to guide the management and timely discharge of patients who have been assessed by an Aged Care Assessment Team (ACAT) as being eligible for Commonwealth funded aged care services and require this level of care on discharge from hospital.

The older patient waiting for aged care services is identified as:

- occupying an acute public hospital bed.
- no longer requiring acute, subacute or rehabilitation care but requiring maintenance care.
- having a current approval by an ACAT as eligible for permanent care in a RACF or for a Home Care Package.
- medically fit for discharge by the treating hospital team.
- having an identified representative who is aware of and who consents to discharge plans including temporary transfer to a Multi-Purpose Service (MPS) site or small hospital or permanent/respite residential care (if appropriate).

Patients admitted/transferred to an MPS site who meet the above criteria are classified as ‘flexible care’ type and are therefore excluded from this policy directive.

Note: For patients under 65 years of age follow the National Disability Insurance Scheme pathway.

The following principles apply in caring for patients who are waiting for aged care services in hospital:

- Patients will be treated with dignity and respect.
- Patients will be encouraged and supported to participate in decision making about their 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 will be involved in decision making where appropriate.
- Coordination of care and multidisciplinary teamwork is ensured so that patients receive the best possible care in the setting that best meets their needs.
- Care is individualised and reflects the patient’s needs, values and preferences.

(Principles of Care – Australian Commission on Safety and Quality in Healthcare, 2020)

2.1 Identification of Patients Awaiting Aged Care Services (PAACS)

- Patients must be identified as soon as possible, during their hospital admission, as potentially requiring aged care services on discharge as they are known to functionally decline the longer they stay in hospital.
- A staff member must be assigned as the key contact person responsible for liaising with the hospital team and the patient (or an identified representative) once the patient has been identified as requiring aged care services.
- Key indicators will assist in the identification of a patient who may need referral to ACAT for approval for aged care services if one is not already in place.
- The multi-disciplinary team must undertake assessment of the key indicators at all stages of the patient's episode of care (e.g. preadmission clinic, emergency department, on admission to acute and subacute care).
- The key indicator questions include but are not limited to:
  - Is the patient currently living alone with or without additional supports in place?
  - Has the patient recently presented to hospital requiring treatment? If so, why?
  - Does the patient have significant cognitive impairment/dementia?
  - Does the patient have significant behavioural concerns, and is potentially at risk of self-harm or a risk to others?
  - Is the patient able to perform basic tasks of daily living?
  - Is the patient a high risk of falls?
  - Is there progressive deterioration in the patient's physical, mental or functional status, or is the level of care currently available to the patient indicating that a return to their home is not a feasible option?

2.2 The Key Contact:

- Is a member of the Health Team who is a central figure in the PAACS Transition Process.
- Is identified during the patient's inpatient admission at a time where likely discharge will be to a RACF or Home Care Package.
- Is a member of the multidisciplinary team who supports compliance with the WACHS Management of Patients Awaiting Aged Care Services Policy Directive.
- The Key Contact person:
- Introduces their role to patient/ family within 24 hours of PAACS Care Type change or initial discussions about RACF placement from the inpatient setting – whichever comes first.
- Identifies the support people a patient wants involved in communications and decision making about their care and acts as the primary point of contact.
- Collates all relevant clinical and social information from multidisciplinary team and patient/representative to support discharge planning.
- Explain the potential risks of remaining in hospital to the patient and their representative.
- Provides Patients Waiting for Aged Care Services brochure, Australian Healthcare Rights and supports access to the MyAgedCare website https://www.myagedcare.gov.au/ and provides patient/representative with Your Guide to Home Care Package Services or Steps to Enter an Aged Care Home
- If English is not their preferred language or there are other perceived language barriers, an interpreter service should be offered.

Printed or saved electronic copies of this policy document are considered uncontrolled.
Always source the current version from WACHS HealthPoint Policies.

- Completes the MR66.10.2 WACHS Awaiting Aged Care Services Transition Plan in consultation with the patient and/or their representative. This plan outlines the agreed RACF application process and is filed in patient's medical record; a copy provided to the patient and their representative.
- Facilitates family meetings as required with the treating team to discuss patients' care needs, concerns and actions identified to facilitate discharge/transfer planning.
- Advises the patient and their representative of the expectation to waitlist a minimum of two RACFs/or temporary transfer to an MPS site and encourages them to accept the first available appropriate place even if this is not in their preferred facility. The patient can continue to wait for their preferred RACF at the location that has the first vacancy.
- Confirms wait listing with the preferred services and/or facilities, provides information to the site as needed, identifies any complex discharge triggers and monitors progress for vacancies at the preferred RACF.
- Links the patient and/or their 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 Complex Admissions

The key contact person must identify any complex discharge issues and together with the multidisciplinary team put strategies in place to regularly check if the patient is on track as per the MR66.10.2 WACHS Awaiting Aged Care Services Transition Plan. Screening of risk may identify cognitive, behavioural, mental and physical conditions or social issues that may compound risks for the patient.

In the case a temporary bed is available; transfer of a patient to the facility will take place following medical clearance. The patient and their representative must be informed that this is a temporary measure. Any issues or concerns and the identification of a long-term placement must be conducted by the hospital team at this site.

If the patient and/or their representative decline a place in a residential facility or decline a temporary bed in another facility or health service site, the escalation procedure at Section 5.2 must be initiated.

2.4 Discharge/Transfer Planning

- An explanation must be given by the health service provider to the patient and their representative, both verbally and in writing, that the patient is to be charged a daily care fee for accommodation and nursing care while waiting in hospital and when non-acute. Daily charges commence after 35 consecutive days in hospital (Health Insurance Act 1973 and Private Health Insurance Act).
- The 35 day qualifying period may accrue in a single or in 2 or more hospitals. Transferring between hospitals has no effect on the qualifying period.
  Note: Patients who meet the qualifying 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 2020-21)

Printed or saved electronic copies of this policy document are considered uncontrolled.
Always source the current version from WACHS HealthPoint Policies.

- While the patient cannot be discharged from hospital until their acute or subacute care episode is complete, planning for services and additional care must commence as soon as possible following hospital admission.
- Timely referral must be made to appropriate specialist services for further management and consideration of ongoing care options if required. This referral can occur in parallel with other acute services. (Completion of the Blaylock Tool on the MR111 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 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 to a HCP, the ACAT assessment must be completed in the patient’s home to reduce impact of staying in hospital. Emergency CHSP or private services can be commenced until a package becomes available. (This should only be considered where the patient has carer or family support available).
- The discharge/transfer management plan must:
    - Detail an estimated date of discharge to a suitable 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 placement.
- 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.
- My Aged Care information and RACF options must be discussed in parallel to rehabilitation to prepare the patient for future transition to a RACF if required.
- If the patient is unable to participate in decision making and does not have family members or a guardian to assist in this process, the Office of the Public Advocate must be engaged.
- For the patient with a cognitive impairment or impaired decision-making diagnosis, Guardianship and/or Administration Orders from the State Administrative Tribunal (SAT) may be required before waitlisting and discharge plans can be actioned. The SAT application must be completed and lodged as soon as possible. (WACHS Impaired Decision-Making Capacity Procedure).
- Following agreement about the discharge destination, the key contact person must liaise with the facility/services regarding the transfer of care.

2.5 Escalation Planning

2.5.1 Early Recognition Indicators

- 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 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.

Printed or saved electronic copies of this policy document are considered uncontrolled.
Always source the current version from WACHS HealthPoint Policies.

  - Frequent changes to discharge plan, either by family, hospital or chosen RACF.
  - Lack of flexibility by family in which facility the patient may be placed
  - Lack of suitable options for patient due to highly complex care needs, including behaviours of concern or cultural needs.
  - 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.
  - Complex financial issues e.g. hardship
  - Delay in accessing guardianship services through the OPA or waiting for State Administrative Tribunal interventions.
  -

2.5.2 Escalation Plan

- The following escalation strategies relate to difficulties in accessing RACF placements, particularly in instances where patient and or their representative has refused to accept an appropriate offer of placement. The escalation strategies can also be adapted in the case of other barriers that are precluding transfer of a patient.
- The key contact person must arrange a family meeting to support the patient and their representative to engage with the discharge process. Attendees must include the patient (where appropriate), family/carer/guardian, medical and multidisciplinary team, Nurse Manager and Operations Manager (as appropriate) This meeting must:
  - Allow the patient and/or their representative 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 the acute hospital setting is associated with adverse outcomes for older people.
  - Review alternative discharge options including discharge into the care of the family and additional RACF waitlisting
  - Key contact person ensures family aware of requirement to visit available homes where possible within 24 hours of being notified of a vacancy to support discharge planning.
  - If no follow up has occurred within the 24-hour period or if there remains a dispute or disagreement, the key contact person is to advise the Ops Manager who may be required to discuss concerns with the OPA
- The key contact person must summarise concerns raised, information provided, agreed actions and persons responsible for these actions in the patient's health record. Outcome of escalation is discharge within an agreed timeframe.

3. Definitions

Aged Care Assessment Team (ACAT)	ACATs conduct a comprehensive assessment of the restorative, physical, medical, psychological, cultural and social dimensions of a person's 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.
Carer	Carers can include family members, next of kin, friends or neighbours who have been identified as providing regular and sustained care and assistance to the care recipient. A Carer may also be the care recipient's advocate.
DRG	Diagnostic Related Group
Flexible Care	Flexible care means care provided in a residential or community setting through an aged care service that addresses the needs of the care recipients in alternative ways to the care provided through residential care services and in-home services.
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.
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	Residential Aged Care is care that is provided to a person in a residential facility in which the person resides.
Subacute care	Specialised multi-disciplinary care in which the primary need for care is optimisation of the patient's functioning and quality of life.

4. 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 MP 0058/17 Admission Policy.
- Providing and maintaining local procedures to facilitate correct recording and reporting of activity (WA Health MP 0036/16 Data Reporting Requirements for Episodes of Admitted Maintenance Care).
- Ensuring activity data is compliant with this procedure prior to submission to the Aged Care Directorate.

Operations Manager is responsible for:

- Reviewing the case, 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 are responsible for:

- Ensuring implementation of the policy across the region and monitoring compliance.

All Staff are:

- Required to work within policies and guidelines to make sure that WACHS is a safe, equitable and positive place to be.
- Responsible for appropriate discharge and care planning and completing forms and documents in line with processes and standards.

5. Compliance

Failure to comply with this policy document may constitute a breach of the WA Health system MP0031/16 Code of Conduct (Code). The Code is part of the Integrity Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (WA) 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 is mandatory.

6. Records Management

All WACHS clinical records must be managed in accordance with Health Record Management Policy.

7. Evaluation

The WACHS Aged Care Directorate requires each hospital to report the number of patients awaiting aged care services on a quarterly basis. This information is to be utilised and monitored in Quarterly Regional Performance Reporting.
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.

8. Standards

National Safety and Quality Health Service Standards: 1, 2, 5.3, 5.4, 6
National Standards for Disability Services: 1, 3, 4, 5, 6

9. 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)

10. References

Homecare Package Calculation of your cost of care form (SA456)
My Aged Care – Consumer and Service Provider web portal
Victoria Government Minimising the risks of transitions
Victoria Government Providing best care for older people in hospital
The Australian Charter of Healthcare Rights

11. Related WACHS Forms

MR 111 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

12. Related Policy Documents

WACHS Admission, Discharge and Intra-Hospital Transfer Clinical Practice Standard
WACHS Adults With Impaired Decision Making Capacity Procedure

13. Related WA Health System Policies

MP 0058/17 Admission Policy
MP 0036/16 Data Reporting Requirements for Episodes of Admitted Maintenance Care.
OD 0290/10 Transition Care for the Older Person
WA Health Fees and Charges Manual 2019-20

14. Policy Framework

Clinical Services Planning and Programs Policy Framework
Information Management Policy Framework

15. Appendix

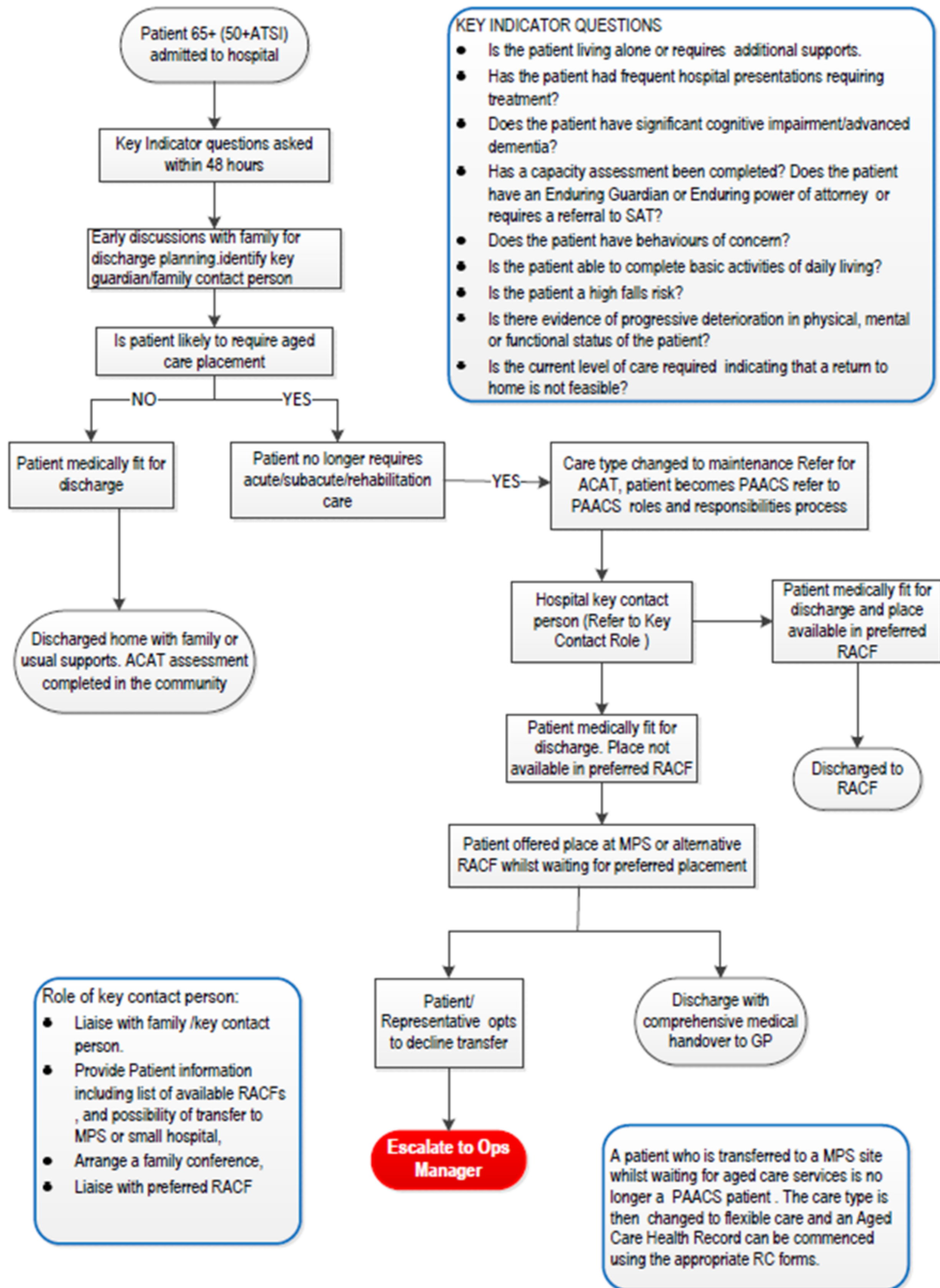
Appendix 1: PAACS Patient Hospital Journey

This document can be made available in alternative formats on request for a person with a disability

Contact:	Senior Project Officer Aged Care (C. Hunter)		
Directorate:	Health Programs - Aged Care	EDRMS Record #	ED-CO-17-58512
Version:	2.00	Date Published:	03 August 2020

Copyright to this material is vested in the State of Western Australia unless otherwise indicated. Apart from any fair dealing for the purposes of private study, research, criticism or review, as permitted under the provisions of the *Copyright Act 1968*, no part may be reproduced or re-used for any purposes whatsoever without written permission of the State of Western Australia.

Appendix 1 - PAACS Patient Hospital Journey



Printed or saved electronic copies of this policy document are considered uncontrolled.
Always source the current version from WACHS HealthPoint Policies.