Patients Awaiting Aged Care Services Procedure

1. Purpose

In accordance with the WA Health MP 0173/22 Patients Awaiting Aged Care Services Policy, Patients Awaiting Aged Care Services (PAACS) are admitted older patients **(65 years and over or 50 years and over for Aboriginal and Torres Strait Islander people)** who are medically cleared and no longer require acute care but require access to aged care services to be safely discharged. Discharge options include: home with additional support, residential aged care or transitional care services.

For Aboriginal patients, discharge planning and aged care service pathways should consider cultural safety, connection to Country, family and community supports, language needs, access to Aboriginal health staff, and the potential impact of transfer away from the patient's usual place of care.

1.1 Guiding Principles

- Assertive flow management is important to maintaining safe clinical care for all patients, and escalation of discharge barriers is the responsibility of all clinical staff
- An acute hospital bed is not the most appropriate or safest place for medically-well patients.
- PAACS should be identified early in their patient journey and staff should commence discharge discussions and expectations at the point of hospital admission.
- Cultural considerations must be prioritised in the delivery of care for Aboriginal and Torres Strait Islander people aged 50 years and over.
- Patients who are medically ready for discharge should not remain in hospital while undertaking aged care related decision making or while waiting for their preferred service.
- Discharge planning must consider all available community and residential discharge options, based on clinical appropriateness, patient preferences, and service availability, **with priority given to discharging home with supports.**
- If there are no local residential or community discharge programs available, staff should prioritise transferring PAACS to smaller sites for their ongoing care.
- Patients should be supported to participate in decisions about their care to the greatest extent possible, including through supported decision-making approaches where appropriate.
- Individual preferences cannot take precedence over managing hospital-wide clinical risk.
- Clear escalation pathways are available to support frontline clinicians when refusal to accept an offer of placement or transfer to another WA Country Health Services (WACHS) site occurs (see 2.6).

2. Procedure

2.1 Early identification of PAACS

- Discharge planning for older patients must commence at the point of hospital presentation/admission with the inclusion of the multi-disciplinary team, including proactive access to Aboriginal Liaison Officers.

- Clear expectations should be established early so that, once medically stable, older patients are not to remain in an acute hospital while aged-care related decision making occurs or while waiting for their preferred service. This may include transferring to another ward or hospital site within the WA Health network.
- Discharge expectations should be communicated in plain language and in a culturally safe and responsive way, with appropriate time and support for the patient and their family/supporters to understand aged care options, fees, implications and available supports.
- Assessment of decision-making capacity should occur as early as possible and throughout the admission and relevant assessments expedited by the treating team, if clinically indicated.
- Where required, alternate decision makers must be identified and relevant documentation (**Enduring Power of Attorney (EPA)/Enduring Power of Guardianship (EPG)**) sourced and uploaded to the electronic medical record.
- Where clinically indicated and no lawful substitute decision maker exists, referral to the **State Administrative Tribunal (SAT)** should be considered.
- Staff should review the My Aged Care system for any existing aged care approvals and notify the **WACHS Aged Care Assessment Organisation** (formerly Aged Care Assessment Team- ACAT) where an assessment is likely to be required to support discharge planning.

2.2 Patient deemed to be medically cleared for discharge

When the treating Medical Officer has deemed the patient is medically cleared for discharge (MCFD) the following must occur:

- The treating medical officer must meet with the patient and/or family to discuss the change in care type from **Acute** to **Maintenance**.
- Complete **MR24 (Episode of Care form)** to change care type to Maintenance (medical officer signature required).
- Complete MR27 (WACHS External Delay Medically Cleared for Discharge MCFD) form (medical officer to complete) and add MCFD data flag to webPAS.
- Within 24hrs, complete MR66.10.1 (Non-Acute Resource Utilisation Group – Activities of Daily Living (RUG-ADL) Assessment).
- Complete MR 66.10.2 (Awaiting Aged Care Services Transition Plan).
- In accordance with the WA Health Fees and Charges Manual 2025-26, a daily fee may be applied where a patient is medically cleared for discharge and has exceeded a total length of stay of greater than 35 days. Applicable fees and charges need to be discussed with the patient and/or their supporter.
- If a waiver is sought on the grounds of financial hardship, a WACHS Waiver Application Form can be completed and progressed through delegation lines. Only the Chief Executive can approve waivers. Patient expectations should be clearly managed.
- Update webPAS to reflect the change of care type to Maintenance and enter MCFD details (webPAS Reference Table – under development). Care type changes should be completed on webPAS as soon as the patient is medically stable and the MR24 has been completed. Fees are to only apply once the patient exceeds 35 days total length of stay.
- Reinforce expectations with the patient and/or supporters that the acute hospital setting is not intended for ongoing aged care planning once medical clearance has been achieved.

- All conversations should be conducted in a culturally safe way that is understood by the patient and their family/supporters and be documented clearly in the medical record.
- **NOTE:** The role responsible for completing these various tasks may differ across sites. Roles and responsibilities should be established clearly at a local level.

2.3 Aged Care Assessment

- Many patients may have existing approvals for Commonwealth-funded aged care services at the time of hospital admission. Except for Transition Care Program (TCP) approvals (which are only valid for 28 days), approvals do not expire and can be used to liaise with aged care providers to support discharge planning.
- Where approvals are not in place but are required to enable discharge – such as for residential care, residential respite or transitional care - a referral must be made to the **WACHS Aged Care Assessment Organisation**.
- An electronic referral (e-referral) must be initiated for all inpatient assessments.
- Where home care services are necessary to facilitate discharge, urgent services may be accessed via phone referral to My Aged Care. A referral to My Aged Care for assessment for ongoing home care services should be completed at discharge.
- All required information and supporting documentation must be completed and attached. Incomplete referrals are to be rejected and returned to the referrer.
- Referral requirements include the following:
  - for **TCP** referrals (residential or community), relevant allied health reports and the completed TCP referral form must be attached
  - where the patient does not have decision making capacity (see 2.31 below), evidence of an invoked EPG or the outcome of a SAT hearing must be provided
  - patients must be medically stable to be suitable for assessment.
- Assessments for Aboriginal and Torres Strait Islander patients will incorporate culturally appropriate validated tools within the Integrated Assessment Tool (IAT), to deliver culturally safe, trauma aware and healing informed assessments.
- Where assessments are not essential to support acute hospital discharge and can be completed after inpatient discharge, referrals should be submitted via My Aged Care.

2.31 Consent and Decision Making Capacity

For the purposes of consenting to an aged care assessment, the assessor must be satisfied that, at the time of assessment, the patient is able to:

  - make an informed decision about whether their personal information may be disclosed to others
  - consent to the assessment and to the collection of their personal information, and
  - where appropriate, consent to their personal information being used or disclosed by other parties to facilitate service provision, in accordance with My Aged Care consent scripts.
- All reasonable efforts should be made to maximise the patient's participation in decisions prior to substitute decision-making processes being enacted.
- Ensure discussions are culturally safe, use plain language and provide interpreter support where required. Cultural, language or communication differences should not be misinterpreted as impaired decision-making.
- If the individual is unable to consent to the aged care assessment, a lawful substitute decision maker must be implemented, as per section 2.1.

Please note, the Hierarchy of Decision Makers outlined within the WACHS Adults with Impaired Decision Making Capacity Procedure **does not apply to aged care assessments, as these assessments are governed under the Aged Care Act 2024.**

2.32 Assessment Timeframes and Outcomes

- The WACHS Aged Care Assessment Organisation is to deliver assessments for relevant patients within **24hrs of referral**, in accordance with the Patients Awaiting Aged Care Services Policy.
- Once assessment recommendations have been endorsed by an Assessment Delegate, a **Notice of Decision and Support Plan** is to be issued to the individual and/or their supporter.
- Notification of assessment outcomes and referral codes associated with approvals is to be provided to the designated hospital Key Contact.

2.4 Exploring options for discharge

The transition to residential aged care can be an emotionally complex and distressing experience for older people. Feelings of loss, grief, fear, shame, guilt and uncertainty may significantly impact decision-making. This process may be further complicated by family dynamics, separation from a long-term partner or pets, cultural factors, social isolation and loss of community, cognitive or physical decline, and financial concerns.
All care should be taken to recognise and respond to the emotional impact of this transition, ensuring that discussions are conducted sensitively and in a person-centred manner.

Things to consider:

- A **Key Worker** should be identified where possible to act as the primary point of contact for the individual and their supporters throughout the transition process.
- Accredited **interpreter services** must be offered to support effective communication, including spoken language interpreters for individuals whose preferred language is not English and accredited Auslan interpreters for people who are Deaf or hard of hearing.
- **Cultural considerations** must be respected and incorporated into care planning, including:
  - connection to Country
  - kinship and family responsibilities
  - cultural obligations
  - sorry business
  - language needs
  - gender considerations
  - previous experiences of institutional care
  - culturally safe discharge planning
  - impact of relocation away from community
  - access to Aboriginal Community Controlled Health Organisations
  - proactive engagement with Aboriginal Liaison Officers and local Aboriginal services.
- **Family meetings** should be utilised where required to support clear, consistent communication between the multidisciplinary team, the individual and key supporters, and to facilitate shared understanding of care and discharge planning.
- Onward referral for the individual and/or family/carer for support services should be considered on an individual basis.

2.5 Operational requirements

To support timely discharge and appropriate placement, the following operational requirements apply:

- Patients should register at a minimum of three Residential Aged Care Homes (RACHs) or MPS sites.
- Patients should complete the **Services Australia Residential Care - Calculation of your Cost of Care Form (SA457)** form as a priority to assess income and assets.
- Where clinically appropriate, patients should be encouraged to consider state funded aged care programs including:
  - Time to Think (TtT)
  - TCP
  - Residential Respite Pilot (RRP).
- Where operational, sites must utilise the Transition and Aged Care Services (TACS) system and Aged Care Hub (ACH) for referral and coordination purposes.
- Hospital staff must provide accurate, comprehensive and timely documentation to receiving services, including information on:
  - the individual's health and needs
  - behavioural concerns
  - cultural care and communication needs
  - identified triggers, and
  - management strategies.
- Where a patient declines a vacancy within an aged care facility for which they are registered, they are to be discharged either:
  - home with appropriate supports in place, or
  - to the first available and clinically suitable placement within the WA Health Network identified by the site.
- In these circumstances, aged care approvals for Support at Home (SaH) or Commonwealth Home Support Program (CHSP) may be required to facilitate discharge back to the community.
- Where acute bed demand exceeds capacity, it may be necessary to transfer a PAACS patient to another hospital or Multi-Purpose Service (MPS). While patient preferences and cultural risk and impact should be considered wherever possible, expressed consent is not required for transfer within the health network when care is being provided at an appropriate level to meet clinical need. Patients and supporters are to be consulted and encouraged to participate in decision-making, however clinical safety across the health network remains the operational priority.
- Staff can seek support from Social Work or relevant management for assistance to undertake challenging conversations with patients and/or families.
- A patient may be transferred to an MPS as PAACS. The patient is to remain as an admitted patient and only be considered an aged care resident of the MPS once a Service Agreement has been signed.
- Medical acceptance for transfer and medical governance remains with the place-based clinician.
- The requirement of the provision and payment of medications for PAACS remains with WACHS.
- Ongoing efforts must be made to ensure patients receive individualised, patient-centred care while awaiting aged care services, with a focus on reducing the risk of decline through:
  - mobility optimisation
  - delirium prevention
  - meaningful activities
  - minimising deconditioning
  - cognitive support strategies.

- Sites may choose to use Residential Care (RC) forms depending on the requirements of the individual, and if these provide a more suitable model of care framework.
- Staff must minimise the use of restrictive practices during handover and comply with the relevant mandatory policies around the use of restrictive practices. Where unavoidable:
    - obtain informed patient or substitute decision maker consent
    - ensure safe and continuous communication regarding medication management**, in line with the Aged Care Quality Standards.**

Acute Deterioration of a PAACS Patient

If a PAACS patient becomes acutely unwell, the following actions need to be undertaken:

- Assessment of the most appropriate location for care must be undertaken. Transfer back to an acute hospital setting may be required to meet the clinical need.
- Complete **MR24 (Episode of Care form)** to change care type to back to **Acute** (medical officer signature required).
- Update MR27 (WACHS External Delay Medically Cleared for Discharge MCFD) form to indicate a patient is no longer MCFD (medical to complete).

Once the patient is again medically stable, the **process outlined in section 2.2** must be recommenced.

2.6 Escalation pathways

Issues that impact on patient discharge and continuity of care, including patients and/or supporters who decline available services should be escalated to Management as soon as delays are indicated.

Escalation should include a comprehensive summary outlining:

- the patients clinical and care needs
- relevant family and support dynamics
- options explored to date
- reasons for refusal
- engagement with Aboriginal Health staff if relevant
- identified barriers to discharge or transfer.

The relevant Line Manager should engage with the patient and/or family to attempt resolution. This discussion should clearly outline the rationale for the proposed transfer or placement, including impacts on:

- the patient with increased risk of hospital acquired complications, physical deterioration and social isolation, and
- hospital capacity and access to acute services.

Where concerns remain unresolved, further escalation to the relevant **District Director** and, if required, the **Regional Executive Director** should be considered.

District Directors are authorised to make determinations regarding bed capacity pressures and the necessity to transfer a patient to another health service site, where appropriate, if agreement cannot be reached.

In accordance with the Patients Awaiting Aged Care Services Policy, where local escalation processes are unable to resolve discharge barriers, the **Chief Executive (or delegate)** should seek agreement on the most appropriate next steps through the **State Health Operation Centre (SHOC) Nurse Director**.

3. Roles and Responsibilities

Regional Executive Directors are responsible for:

- responding to any discharge delay issues raised by District Directors and escalating to WACHS Executive as required.

District Directors are responsible for:

- responding to discharge delay issues raised by staff and management
- resolving discharge delays in consultation with other key staff and addressing concerns of the patient and/or their supporter
- decision making regarding the need for beds and transferring the patient to another health service site if required
- ensuring staff have access to and apply the requirements of this procedure.

Line Managers and Senior Staff are responsible for:

- responding to discharge delay issues raised by staff
- resolving discharge delays in consultation with other key staff and addressing concerns of the patient and/or their supporter
- ensuring they are familiar with the procedure and policy requirements
- ensuring staff have access to and apply the requirements of this procedure.

WACHS Older Adult Program

- ensure Aged Care Assessment Organisations have adequate resource and support to provide timely hospital assessments
- respond to queries from Department of Health around the implementation of the Patients Awaiting Aged Care Services Policy
- provide subject matter expert advice on PAACS policy and procedure.

All staff are required to comply with the directions in WACHS policies and procedures as per their roles and responsibilities. Guidelines are the recommended course of action for WACHS, and staff are expected to use this information to guide practice. If staff are unsure which policies procedures and guidelines apply to their role or scope of practice, and/or are unsure of the application of directions they should consult their manager in the first instance.

4. Monitoring and Evaluation

The WACHS Older Adult Directorate requires each hospital to record the number of PAACS daily. Accurate identification, documentation and webPAS recording is essential to achieve effective monitoring. Monitoring is to include:

- length of stay in an acute hospital for those requiring placement
- barriers to discharge
- discharges to Residential Aged Care and state funded discharge services
- time from referral to aged care assessment
- time to placement

Monthly reporting of PAACS is to be provided to the Older Adult Program Committee. PAACS data may also be reviewed by Department of Health.

This procedure is to be reviewed within six (6) months of publishing.

5. References

1. My Aged Care Assessment Manual.
2. My Aged Care – Consumer and Health Professional website

6. Definitions

Term	Definition
Aged Care Assessment	An aged care assessment (or aged care needs assessment) determines a person's care needs and the types of Commonwealth-subsidised aged care and services a person may be eligible for. In WA, community aged care assessments are delivered by private organisations as well as relevant ACAT teams in HSPs. Aged care assessments in hospitals are only delivered by HSPs.
Aged Care Hub (ACH)	ACH within the State Health Operations Centre coordinates referrals for State and/or Commonwealth-funded aged care discharge programs, including Transition Care Program, Time to Think and Residential Respite Pilot. The ACH liaise with HSPs and TCP providers to match patients to the most appropriate bed or community place.
Aged Care Quality Standards	Administered by the Aged Care Quality and Safety Commission, the Standards are legislated and apply to all Commonwealth-funded aged care services including residential care, home care, short-term restorative care, transition care, the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, Multi-Purpose Services, and the Commonwealth Home Support Program to ensure safe and quality services
Commonwealth-funded aged care service	Any service subsidised by the Commonwealth under the *Aged Care Act 2024* (Cth). Services include: • Residential care • Residential respite, including Time to Think • TCP (residential and community) • Support at Home Program services, including Restorative Care and End of Life Pathways if applicable. • Grandfathered/transitioned Home Care Packages • Commonwealth Home Support Program • Multi-Purpose Service Program • National Aboriginal and Torres Strait Islander Flexible Aged Care Program
Medically Cleared for Discharge (MCFD)	State-wide data recording for inpatients who are considered medically cleared for discharge but are unable to be discharged due to external barriers.
Nursing Home Type Patient	A patient who has been in a hospital for an extended period (usually over 35 days) and no longer requires

	acute hospital care but still needs nursing care and accommodation.
Older people	For the purposes of the *Aged Care Act 2024 (Cth)*, people aged 65 years and over, or 50 years and over for Aboriginal and Torres Strait Islander people and people who are homeless or at risk of homelessness.
State Health Operations Centre (SHOC)	The SHOC is a WA Health initiative that supports health services to manage emergency department demand and ease system pressures. It brings together key functions from across health, including the WA Virtual Emergency Department, Patient Transport Coordination Hub, System Flow Centre and Aged Care Hub, to improve system-wide monitoring and oversight.
State Administrative Tribunal (SAT)	SAT is an independent body that reviews a wide range of government decisions and resolves disputes. The role of SAT is to make legal decisions for adults who may no longer have the capacity to make certain personal, medical, financial or legal decisions for themselves
Residential Aged Care	Residential aged care is for older people who can no longer live safely in their own home. It includes accommodation and personal care 24 hours a day, as well as access to nursing and general health care services. The Commonwealth Government subsidises aged care homes to provide residential care to eligible people. Referred to as Residential Aged Care Home (RACH), replacing Residential Aged Care Facility (RACF)
Residential Respite Pilot (RRP)	Supports older people with temporary respite care in a residential aged care setting after a hospital stay. Provides older people with time to think and make decisions about permanent aged care, while ensuring hospital beds are available for those who need them. Availability of beds is based on vacancies being offered by participating aged care providers.
Supporter	A person that the individual trusts to help them understand information and communicate their own decisions. For the purposes of the matters relating to the Aged Care Act 2024, a **registered supporter** can: • Help older people to make and communicate their own decisions about aged care. This might include speaking to My Aged Care, aged care assessors, aged care providers and workers, and the Aged Care Quality and Safety Commission, and • Request, access and receive information about the older person they support. NOTE: this person is not necessarily a substitute decision maker
Transition Care Program and Aged Care Services system (TACS)	TCP is a joint Commonwealth and State funded aged care service administered under the *Aged Care Act 2024*. The program aims to provide restorative care to maintain or improve the functioning of older people after their hospital

	stay by providing short term care for up to 12 weeks (with an ACA approved extension) either in a TCP service or in the person's home.
Transition Care Program (TCP) service	An external aged care provider who contracts with the Department of Health to provide transition care services for the Transition Care Program.
Time to Think (TtT)	Supports older people with temporary respite care in a residential aged care setting after a hospital stay. Provides older people with time to think and make decisions about permanent aged care, while ensuring hospital beds are available for those who need them. Dedicated beds are set aside for TtT by providers.

7. Document Summary

Coverage	WACHS wide
Audience	Medical, nursing, allied health and executive managers
Records Management	Corporate Recordkeeping Compliance Policy Health Record Management Policy
Related Legislation	*Aged Care Act 2024 (Cth)* (Commonwealth) *Guardianship and Administration Act 1990* (WA) *Privacy Act (1988)* *Health Services Act (2016)* *Aged Care Quality and Safety Commission Act (2018)*
Related Mandatory Policies / Frameworks	• Clinical Services Planning and Programs Policy • Information Management Policy Framework • MP 0071/07 Aboriginal Health and Wellbeing Policy • MP 0095/18 Clinical Handover Policy • MP 0164/21 Patient Activity Data • MP 0171/22 Recognising and Responding to Acute Deterioration Policy • MP 0173/22 Patients Awaiting Aged Care Services Policy • MP0186/24 Use of Restrictive Practices in Non-Authorised Healthcare Settings Policy • WA Aboriginal Health and Wellbeing Framework 2015–2030
Related WACHS Policy Documents	• Adults with Impaired Decision Making Capacity Procedure
Other Related Documents	• WA Health Fees and Charges Manual 2025-26 • My Aged Care Assessment Manual.
Related Forms	• MR24 (Episode of Care form) • MR27 (WACHS External Delay Medically Cleared for Discharge MCFD) • 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 • WACHS Waiver Application Form
Related Training	Available from MyLearning: • Restrictive Practices and Restraints and Behavioural Plans (AC19 EL2) 2022 (optional) • Altura: Dementia – Engaging People in Meaningful Activities (DEMA EL2) (optional)
Aboriginal Health Impact Statement Declaration (ISD)	ISD Record ID: 5827
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, 5.05, 5.06, 5.07, 5.10, 5.11, 5.12, 5.13, 5.35, 5.366.01, 6.02, 6.03, 6.04, 6.07, 6.08, 6.09, 6.10, 6.11, 8.03, 8.05.

8. 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
4.00	23 June 2026	23 June 2026	• Document rewritten to incorporate new Aged Care Act (2024) and updated Patients Awaiting Aged Care Services Policy

9. Approval

Policy Owner	Chief Operating Officer
Co-approver	Executive Director Nursing & Midwifery Executive Director Clinical Excellence
Contact	Program Manager Aged Care Assessment Program and Older Person Patient Flow
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 process